

DOCUMENT RESUME

ED 233 215

CE 036 750

TITLE School Nurse Handbook for the School Health Program.

INSTITUTION Texas Education Agency, Austin.

PUB DATE [83]

NOTE 401p.

PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC17 Plus Postage.

DESCRIPTORS Disease Control; Educational Resources; Elementary Secondary Education; Guidelines; *Health Education; Health Materials; Health Programs; History; Inservice Education; Legislation; Nursing; Program Development; Program Evaluation; *Program Implementation; *School Health Services; *School Nurses

IDENTIFIERS *Texas

ABSTRACT

The purpose of this handbook, a revision of Texas Education Agency Bulletin 752 (1975), is to assist administrators and school nurses in planning and implementing the school health program. The guide contains eight sections. Following the history of the school health program in the first section, the second and third provide guidelines for the administration and framework of a school health program. Topics covered include the components of a school health program; developing a philosophy, a purpose, goals, and policies; planning, implementing, and evaluating a school health program; an organizational chart for a school health program; and working with advisory committees. The fourth section covers school nursing services, including personnel, certification, and school nurse evaluation, while the fifth section details the responsibility of the school nurse. Responsibilities falling under the nurse's purview include disaster organization, emergency and illness care, communicable disease control, immunizations, reportable diseases of Texas, child abuse reporting, and suicide prevention. In the sixth section, information is provided for school health nurse use in health counseling, health instruction, health screening, growth and development screening, dental screening, vision screening, audiometric screening, scoliosis screening, and hypertension screening. The final two sections cover accountability and inservice education for school health nurses. Appendixes to the guide contain listings of resource organizations and literature, legislation with impacts upon school health programs, and sample forms. (KC)

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HEALTH SERVICES
HEALTH EDUCATION
SCHOOL ENVIRONMENT

SCHOOL NURSE HANDBOOK FOR THE SCHOOL HEALTH PROGRAM TEXAS EDUCATION AGENCY

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Foreword

The purpose of this handbook, a revision of Texas Education Agency Bulletin 752 (1975), is to assist administrators, and school nurses in planning and implementing the school health program.

Through the educational system, students may be taught the rudiments of self-care and health consumer awareness. Schools are encouraged to provide health education, health counseling, and health screening in order to develop an enlightened student and future adult.

The Texas Education Agency gratefully acknowledges the many contributions made by school nurses and physicians throughout the state. This handbook will provide direction for the school health program.

Raymon L. Bynum
Commissioner of Education

Introduction

Boards of education, in cooperation with state and local health departments and other community agencies, are expected to authorize the necessary procedures for protecting the health of school children.

The school health program is governed by state and federal laws and State Board of Education rules. Legislation provides for the control of communicable disease, vision screening, medication in school, immunizations, and certain curricular offerings. Health and physical education are required in the Texas school curriculum.

Texas Administrative Code (TAC) §85.41 outlines the requirements for the school health program (See Section C-4.1). In addition to these specific rules, the courts have upheld local school board regulations as long as they have not conflicted with state law.

Standards developed by the Texas Department of Health include refinements of immunization requirements, recommendations regarding tuberculosis screening, and vision screening.

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Section A
History of the School Health Program

Section A History of the School Health Program

History of the School Health Program

Section A

Introduction

The school health program of today has evolved over 150 years through the interrelationship of three major professions: education, nursing and medicine. This evolution has progressed from an early emphasis on health education and teaching self-care through progressive stages of prevention and detection of diseases, sanitation, intervention of illness and handicapping conditions and health promotion. Now it has returned to teaching students to make responsible decisions regarding self-care.

European School Health Services

The earliest recorded school health service activities began in 1833 with a French law requiring communities to keep school houses clean. A few years later female supervisors of kindergarten schools were instructed to watch over the health of "little children." A Paris statute of 1842-43 required that every school be visited by a physician to "inspect the localities" and observe the general health of the children.[1]

Although France established the first precedents, it was almost 40 years before school health programs were developed in other European cities. In 1874, Brussels established a program by appointing physicians to visit schools three times each month. Similar programs were founded in Antwerp in 1882, Moscow in 1886, Leipzig and London in 1891 and in Weisbaden in 1896.[2] Weisbaden provided the most comprehensive and successful program of health examinations, which was generally adopted throughout Germany and widely copied by other nations.

Efforts toward health protection spread quickly to other countries. An 1899 law passed in Rumania decreed that all school children be examined yearly. Later, the national "Medical Inspection Act" of 1908 enacted by Parliament represented the forerunner of the present school health services in Great Britain.[3]

Shortly after the turn of the century, Argentina established a comprehensive health program which provided for "vaccinations of school children, the inspection of school sanitation conditions, the visiting of sick children in their homes, the identification of communicable diseases, and the provision of medical advice to teachers and pupils." [4]

School health service activities in the United States can be traced to the latter part of the 19th century. However, William A. Alcott, a distinguished educator, physician, and school health pioneer, wrote in 1840:

Until the teachers of the schools can be trained to a thorough and practical knowledge of the science of human life and health there will be a thousand things of frequent, if not daily, recurrence in every school which will require medical attention.[5]

It was 10 years later that the idea of teaching students the philosophy of self-care was first documented. In 1850, Lemuel Shattuck proposed that teachers appoint a "sanitary committee of scholars" at the beginning of school. On the first day of each month the committee should appraise the class. Shattuck stated:

Such a measure is simple, would take but a few minutes each day, and cannot operate otherwise than usefully upon the children, in forming habits of exact observation, and in making a personal application of the laws of health and life to themselves. This is education of an eminently practical character, and of the highest importance.[6]

New York in 1860 passed legislation to "encourage and provide for the general vaccination of all children and persons attending schools in the state." This law established long before compulsory education, recognized the schools as the most organized structure for access to the school-age population. However, the legislation was ineffectual because it did not specify the responsibility for administering vaccinations nor the source of funding. Nevertheless, New York was instrumental in formulating many early school health laws.[7] Later, the Elmira, N.Y., Board of Education (1872) employed a "sanitary superintendent" to cope with an alarming prevalence of smallpox. His responsibilities included: frequent examinations of school children, exclusion of the unvaccinated, and supervision of sanitary conditions.[8]

"The first public school medical officer in the United States was appointed by the City of New York in 1892." [9] By 1894, some 50 "medical visitors" who visited schools each day and examined "all children thought by their teachers to be ailing" were appointed in Boston. Similar programs, "to inspect pupils suspected of having contagious diseases," were begun in Chicago in 1895, New York in 1897, and Philadelphia in 1898.[10]

Broadening Scope of Health Services

By the close of the century, the Connecticut legislature began broadening the scope of school health services when it made the examination of all school children for visual defects compulsory. New York in 1902 required routine inspection of all pupils to detect contagious eye and skin diseases. By 1904 Vermont had passed legislation requiring "annual examination of the eyes, ears, and throats of school children." [11]

Further expansion of the concept and practice of the school health program included beginning of dental health work. In 1898 the Cleveland Dental Society requested that dental inspections be introduced into schools. Yet, it was not until 1910 that all city school children received dental examinations and four centrally located clinics for treatment were established. [12]

Establishment of School Nursing Services

Medical inspections were extended to include "nuisance diseases," such as pediculosis, scabies, and ringworm. Students were excluded from school with little follow-up and many failed to return to school, "remaining truant and contributing to excessively high absenteeism in public schools." [13] To alleviate this problem in New York, a Henry Street visiting nurse was assigned to conduct demonstrations in a few schools. "The nurse counseled parents and encouraged them to secure needed treatment or to follow proper care procedures. The experiment was so successful that the first municipally supported school nursing service in the United States evolved in New York in 1902." [14]

Rapid growth of school nursing services followed. By 1911 a total of 102 American cities employed 415 school nurses. [15] In most instances, the nurses were paid through visiting nurse associations, settlement houses, or similar organizations.

First Special Education Program

The next major change in the school health program was a forerunner of today's special education program health services. "Open-air schools, intended generally for the more efficient care and instruction of physically below-par children" were conceived in Germany in 1904. By 1908 open-air schools had been established in Providence, Boston, New York, and Chicago. "Open-air classes focused attention on the need for controlling tuberculosis and undernourishment in school-age children." [16]

Change in Educational Philosophy

During the first half of the 20th century, educational philosophy shifted from a solely subject matter approach to include attention to child growth and development. Matters such as growth, hearing, vision, nutrition, and general health status began to receive a new emphasis. School administrators became increasingly concerned with services which safeguard good health and have accepted these efforts as essential to effective education. [17]

Expansion of Public Health Activities

Spurred by these changes in the educational philosophy, the expansion of public health activities was begun. "Public health programs related to protecting and promoting child health received emphasis and were directed toward infants, preschool children, and children of school age." [18] The growth of the pediatric field of medicine made great advances in child growth and development, nutrition, and treatment of handicapping conditions.

Impact of World Wars

The impact of a national crisis or emergency produced by World War I and World War II had particular influence on the school health program. Wood and Rowell reported the dynamics of the First World War on school health services:

Because of the war as such and because of the economic readjustments which followed it, the period from 1914 to 1926 may be considered one of a typical progress and of undertermined significance in school health work, except that the poor condition (mental and physical) of recruits served as an impetus of increasing interest in more comprehensive public health programs.[19]

Much publicity was given to the large number of draftee rejections for disqualifying defects during both World Wars. While evaluations were inconsistent, the information caused many schools to reassess their health service efforts. Patty indicates that "almost all of the states enacted laws concerning health and physical education between 1918 and 1921." [20]

Groups Instrumental in Providing Leadership

The cooperative effort of persons from various disciplines has provided a focused direction for the school health program. Professional organizations, voluntary associations, private groups, federal agencies, and colleges and universities have shared guidance and leadership in the development of school health policies and procedures.[21] Major contributors include: Joint Committee on Health Problems in Education of the National Education Association and American Medical Association; American Association for Health, Physical Education and Recreation; American Public Health Association; American School Health Association; American Nurses Association; American Academy of Pediatrics; and the U.S. Department of Health and Human Services.

School Health Today

A more recent look at the school health program both nationwide and in Texas in the later part of the 20th century finds emphasis placed on four major areas: prevention, intervention, promotion, and health teaching. Brophy, consultant for the California Department of Education, states that prevention serves to validate the very nature of school health services. Since the inception of the school health program the emphasis on wellness, prevention of illness and transmission of disease, and early detection of possible defects including follow-up procedures have been given top priority. [22]

With the passage of the Education for All Handicapped Children Act of 1975 (PL 94-142) schools have found it necessary to provide an educational setting for children with many handicapping conditions. Intervention techniques used by school nurses have allowed many students with specialized physical health care needs to be placed in non-clinical settings. Also, school nurses are involved in crisis intervention on a daily basis with students presenting problems related to alcohol and drugs, venereal disease, pregnancy, abuse and neglect, family discord, and many other concerns related to health and personal living.[23]

School nurses often serve as catalysts for promoting health through formal and informal health education. The school health programs require nurses to serve as resource persons, to identify other resources, and to assist in and developing programs in preventive health education.

Conclusion

Many factors have influenced the 150-year development of the school health program. Twenty years ago Wilson, a physician and historian, noted the 20 factors which continue to serve as points of direction today. They include:

1. Successful school health practices in foreign countries, particularly European nations
2. Changes in the philosophy of education
3. Alterations in social viewpoints regarding child health and welfare
4. Expansion of public health programs

5. Medical and scientific progress
6. Impact of health programs stemming from war conditions and other periods of national crisis
7. Development of the behavioral sciences with greater understanding of growth and development characteristics
8. Leadership and inspiration by pioneering individuals interested in the well-being of all school children
9. Contributions by professional health associations, governmental health agencies, voluntary health organizations, and institutions of higher learning
10. Development of organized civic groups whose concern about health stemmed from the interest of school patrons
11. Financial support, particularly in the fields of research, demonstration, and experimentation, by philanthropic organizations interested in child welfare.

These and other factors have shared in the organization, integration, and improvement of programs of school health services. All have contributed directly or indirectly in the development of the philosophy which guides operational practices today.[24]

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Section B

Administration

Section B	Administration
1.0	Components of a School Health Program
1.1	Health Services
1.2	Health Education
1.3	School Environment
1.31	Safety Standards for School Environment—Texas Education Agency
1.32	Recommended First Aid Facilities—Texas Department of Health Resources

Section B Administration

The purpose of this publication is to suggest methods of organizing and conducting an adequate school health program. Initiating and developing the program is the responsibility of the superintendent who, with the support of the board of trustees, relies on the cooperation of the staff, students, parents, and other concerned citizens. Community participation is desirable at all stages of planning, organizing, and implementing the program.

School district administrators will of necessity delegate some of the responsibility to others, particularly to school nurses. In all instances, however, the final approval of the health program including services, personnel, facilities, and budgets, lies with superintendents and trustees.

Components of a School Health Program

Section B-1.0

Three widely accepted components of a school health program are:

- Health Services
- Health Education
- School Environment

The *School Nurse Handbook for the School Health Program* is directed primarily to the administration of the program as it relates to these aspects in accordance with the Texas Administrative Code (TAC) §85.41 (see Section BB-13.0).

Health Services

Section B-1.1

Health services must be comprehensive in design to meet the educational objectives and health needs of its population. Health services should serve all students in affording them the opportunity to reach maximum mental, physical, and emotional potential. Emphasis should be placed on the relationship of a student's health to successful living and learning.

The health services portion of the school health program utilizes personnel from nursing, medical, dental, other professional disciplines, and ancillary health paraprofessionals. The recommended student services provided through a school health services program are discussed in Section F.

Health Education

Section B-1.2

The promotion of health and health education should be the basis for a school health program's immediate, intermediate, and long-term goals. School nurses should make use of every opportunity while talking with students, administrators, parents, and/or community leaders to teach on-going methods of acquiring better health.

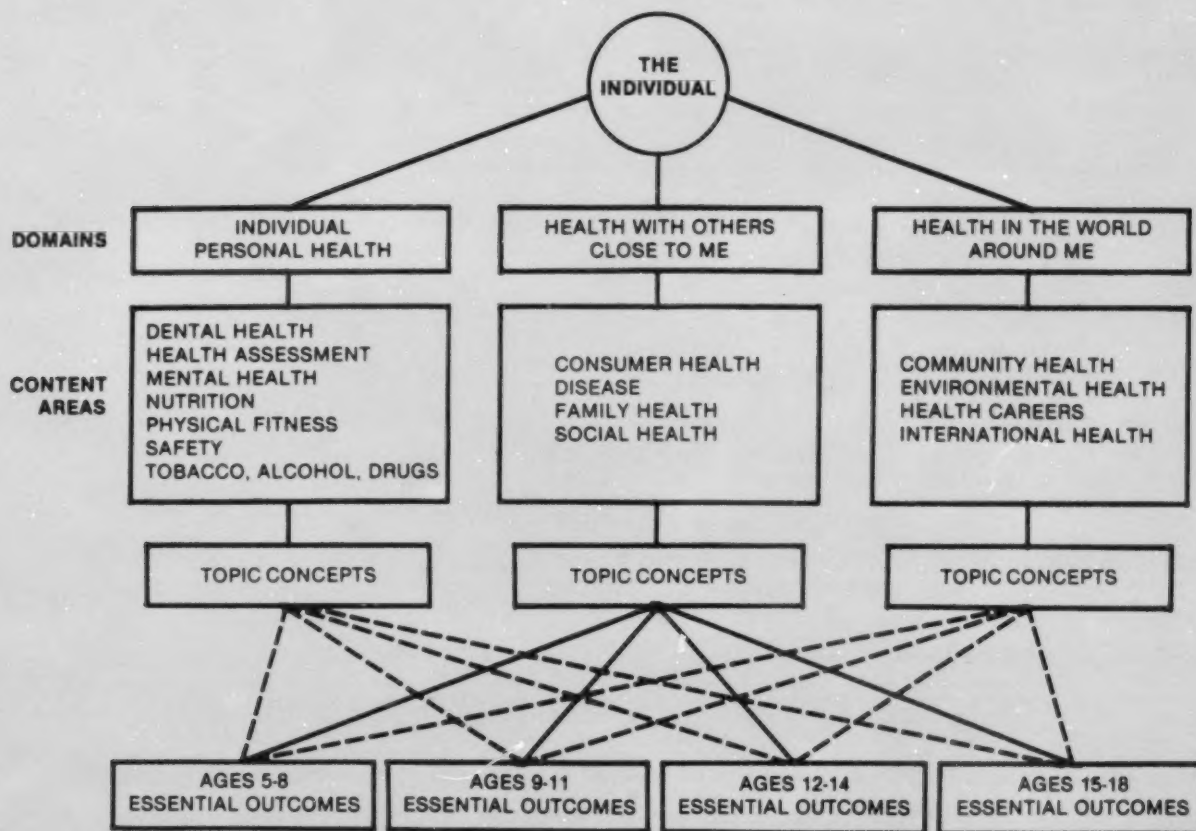
The primary role of the school health program is not one of formal health education. School nurses are not expected to have responsibility for regular health classes. Yet, the school nurse and other professionals—through informal student contact, as guest speakers on health issues, and as health advocate resource persons—have vital input to health education.

Nurse Promotes Health Education By

- Utilizing all screening programs and first aid procedures as learning experiences for the student.
- Assisting the classroom teacher by presenting health concepts in science, biology, home and family living, child development, physical education, and health classes.
- Supplementing the regular classroom curriculum, i.e., dental health, nutrition, drug abuse, smoking, first aid, personal hygiene, and cardiopulmonary resuscitation.

- Observing special health recognition weeks or months as unique educational opportunities, i.e., Health Awareness Week, Dental Health Week, Save Your Vision Week, Correct Posture Month, Nutrition Month, Better Hearing and Speech Month.
- Serving as a resource person for teachers in obtaining special materials such as films and supplies available from community agencies as well as from education service centers.
- Maintaining attractive, relevant bulletin boards of current health interest.
- Serving on special programs for school-community groups such as Parent-Teacher Associations, pre-school, booster clubs, youth groups, and parent involvement groups.
- Serving as instructor for mini-courses such as mother's aide, baby care, home nursing, first aid, nutrition, and grooming.
- Conducting inservice training sessions for school personnel in matters pertaining to health, such as sickle cell anemia, hyperactivity, resuscitation, and first aid.
- Planning and teaching health-related subjects. The following page outlines a *recommended* health curriculum, including domains and content areas related to student age groupings. (*Framework for Health Education, K Through 12*, TEA CU1 832 21, 1981, \$2.00.)

FEATURES OF THE FRAMEWORK FOR HEALTH EDUCATION ORGANIZATIONAL FORMAT



School Environment

Section B-1.3

A healthful school environment is one in which students can develop a high level of physical and emotional well being. The development of such an environment requires the cooperation of appropriate persons.

Responsibility of School Board

The local board of education and administrators have a direct and continuing responsibility to provide a safe and healthful school environment for students and staff, including the social and emotional factors related to healthful school living.

The physical environment includes adequate ventilation, temperature control, lighting, seating, maintenance, and safety of buildings and grounds. The environment must be barrier-free or accessible for students with all types of handicapping conditions. This does not mean every facility must be accessible and barrier-free, but rather that the program is accessible in some way to a student with a handicap.

The mental/emotional climate of the school is less tangible. It includes the interaction of students with one another, students with teachers, teacher with teachers, and teachers with administrators. All service staff personnel share in the promotion of positive mental/emotional health within the school.

Each person needs acceptance, recognition, and security to achieve. A healthy emotional climate, providing acceptance, recognition, and security must be nurtured and maintained. Schools are educational facilities where skills for living are learned by example as well as precept. Skills include development of positive health attitudes and practices of students, assistance in making decisions for health or health care, and reinforcement of good health practices learned at home.

Planning and organizing the school day are important aspects of the emotional climate. Scheduling should include time for students to take care of basic physical needs. Change of activity with physical exercise helps to improve learning. Proper emphasis on healthful living habits in the school can influence the student in later life.

To a large degree the healthful school environment is influenced by the attitudes and values of the total school population—students and staff. It is a joint responsibility and can only be achieved through cooperative planning and efforts.

Role of the Nurse

The school nurse is an administrative team member, serving as an advisory and resource person. The nurse must observe environmental factors and, if necessary, convey any concerns regarding sanitation or safety hazards to the principal and the health program administrator. The nurse should emphasize the need for continuing safety awareness in the school.

Nurse May Assist Through

- Periodic inspection of school buildings and grounds for safety and sanitary conditions.
- Periodic inspection of cafeterias.
- Suggestions to the school safety council.
- Work with the principal for correction of undesirable conditions found on the school premises.
- Promotion of satisfactory heating and lighting.

**Safety Standards for School Environment
Texas Education Agency****Section B-1.31**

- Buildings must be fire and wind resistant, preferably not more than two stories in height unless it is necessary to build on a small site.
- Corridors, stairways, and all other features of building construction should meet local, state, and national building standards.
- There should be at least two exits in all buildings.
- Outside doors should be equipped with self-closing devices and panic bolts which should be inspected, oiled, and tested regularly.
- Exit doors from classrooms should open outward and be provided with door checks which hold the door against the wall when open.
- Auditoriums, gymnasiums, and other rooms used by large groups should be located on the ground floor for ready exit.
- Sanitary facilities, toilet rooms, washrooms, and drinking fountains should be in sufficient numbers and located to prevent congestion and facilitate adequate cleaning.
- Lighting in rooms, hallways, stairways, basements, locker rooms, toilet rooms, and store rooms should be adequate with lights at the head and foot of stairs and where needed to prevent accidents and protect vision.
- School furniture and equipment must be safe, regularly inspected, and kept in repair. Machines in shops and laboratories should be equipped with approved safety devices.
- Safety hazards such as slippery floors, splintered doors and handrails, and projections or obstructions in rooms, hallways, and stairways should be eliminated.
- The school building and playground should be in clear view from any direction when approached on the street. Warning signs should be erected and be seen easily by motorists.
- Police officers, caution signs, school safety patrols, and stop lights should be available to protect children at hazardous crossings.
- The school site should be located away from railroads, industries, dangerous streams, and anything which disturbs school by noises or odors.
- School grounds should be level, but with sufficient drainage. Grounds should be free from rocks, holes, ditches, and other obstructions.
- Play areas, if adjacent to streets, should be fenced.
- Safe parking areas, including loading and unloading zones for school buses, should be provided.
- Service driveways should be fenced or marked and should not cross play areas. Driveways should extend from street to school only, and not pass the school to another thoroughfare.
- Flagpoles, monuments, garbage incinerators, and other obstructions should be located away from play areas.
- Playground activities and equipment should be properly supervised. All teachers should receive instructions on proper use of equipment and pass these instructions on to the students.
- Repairs should be made immediately. Inspection of all playground equipment should be made on a regular basis.

Recommended First Aid Facilities
Texas Department of Health Resources

Section B-1.32

1. The first aid room should be in a centralized location.
2. A room should be available for isolation and/or rest for ill or injured students.
3. A bed or cot should be available in the first aid room.
4. A lavatory with hot and cold water should be available in the first aid room.
5. The first aid room should be equipped with an adequate amount of the proper first aid supplies based on needs and usages for the particular facility. The equipment should comply with the list in the Red Cross Manual "Standard First Aid and Personal Safety," and a copy of this manual or its equivalent should be available.
6. First aid supplies should be stored in a locked cabinet, or the first aid room should be locked when unattended. Keys should be readily available with supervised use of supplies.
7. A registered nurse or person trained in first aid should be available in the facility at all times. Training should be provided by a Red Cross instructor or equivalent, licensed physician, or registered nurse.
8. A plan to provide emergency medical treatment to seriously ill or injured persons should be established, and emergency telephone numbers should be posted and readily available.
9. Emergency plans should also be established for weather and fire emergencies.
10. The first aid room and equipment should be kept clean at all times.
11. First aid supplies should be replaced as used so that adequate supplies will be available at all times.
12. Signed permission from parent, guardian, or physician should be obtained before any drugs are administered to a minor, as required by Chapter 35, Title 2 of the Texas Family Code. Records should also be maintained on any medication administered.

Texas Department of Health, "Recommended Environmental Health Practices for Schools" (Austin, Texas: The Department, 1977).

Section C

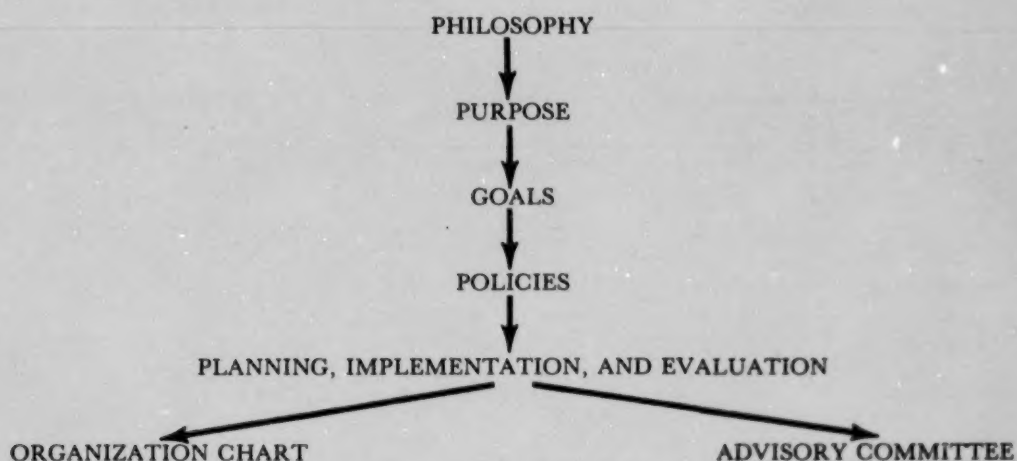
Framework—Guidelines

Section C	Framework—Guidelines
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Section C

Framework—Guidelines

The framework of a school health program is composed of several components. Each element of the framework should build and gain impetus from the other; yet, be an understandable entity. The following components are suggested for a well-coordinated health program.



Developing a Philosophy

Section C-1.0

A program's philosophy is the cornerstone or foundation of its existence. The philosophy provides a point of view, a statement of values, an aspiration for ideal possibilities, and the significance or relationship of concepts pertaining to a school health program. The philosophy answers the question of *why* a health program exists and also queries its *worth*. It lends direction for a program's purpose, goals, and objectives.

A philosophy should be developed jointly by school nurses and administrators and contain emerging concepts which are held important to the local district, personnel, and the health program. Constructs which may be addressed in a school health program philosophy are: the student, health, nursing, health services, and the school.

Section C-1.1



Healthy Independent School District

Healthy Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Health Program Philosophy

The faculty members of the school health program support the philosophy of Healthy Independent School District. In accordance with this philosophy we believe in the holistic student, affirmed as having inalienable rights, intrinsic value, dignity, and responsibility. The student is accepted without judgment in terms of biological, socio-economic, political, cultural, religious, and emotional complexities.

Health is recognized not exclusively as the absence of illness or disease, but as the most desirable level of physiological, psychological, and emotional well-being. We believe that all students have the right to learn how health may better be achieved.

School nursing is acknowledged as being a helping profession. School nurses are student advocates and serve as liaisons between the student, school, community, and home.

The school health program is a vehicle in the advancement of student, staff, and community health and welfare. The program provides assistance in the discovery of barriers which may be hinderances to student learning.

One of the major principles of education has been the achievement and maintenance of good health. The school is an avenue through which meaningful preventive health measures may be initiated. The school setting has a unique advantage in: the promotion of health education; the development of positive healthful attitudes; the maintenance of an environment conducive to optimal health, growth, and learning; and meeting the needs of school students and school personnel.

Developing a Purpose

Section C-2.0

The school health program purpose should be agreed upon and stated by district administrators and nursing administrators. A program purpose is a continuum of the philosophy; it provides direction and information regarding the aim and intent of the health program.

The following sample purpose states the basis for a program and refers to legislative documentation found in TAC §85.41, provided in Section C-4.1, of this handbook.

Section C-2.1



Healthy Independent School District

Healthy Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Health Program Purpose

It is the intent of the school health program to provide health counseling, appraisal, screening, referral, and follow-up through program planning, development, and evaluation.

The primary purpose of Healthy Independent School District's school health program is the optimal maintenance, promotion, protection, and improvement of student, staff, and community health. The school health program personnel work collaboratively with students, parents, educators, staff members, and other community resources to assist the student develop competence to confidently cope with the complexities of life. The program is designed to assure a safe, healthy environment that is conducive to learning, and to provide professional care for those who become ill or injured while at school.

The school health program is no substitute for the health care which parents should provide for children. Rather than relieving parents' responsibilities, this program is established to encourage individuals to utilize the services of a private physician, dentist, optometrist, and/or community health agency.

Developing Goals

Section C-3.0

The goals for a school health program should correspond to the educational goals of the school district. Goal formation follows the establishment of a health program's philosophy and purpose. A program's goals should state achievable expectations derived from problems which have solutions. Goals are statements of *what* a program plans to do and progress to development of district health policies.

Steps in Goal Development

1. Assessment of needs.
2. List goals in order of priority.
3. Evaluate effectiveness of goals achievement.
4. Re-assess needs or new goal formation.

Three areas to be addressed in goals are: Health Services, Health Education, and the School Environment.

Health Services

1. Maximize the quantity of in-class time by reducing the incidence of health-related absenteeism.
 - Decrease the incidence of preventable communicable disease.
 - Ensure adequate immunization in all students.
 - Exclude students with symptoms of communicable disease.
 - Adjust school environment to accommodate student health problems which cause absenteeism.
2. Eliminate or minimize health problems which impair learning by maintaining a health appraisal schedule for students for detection and referral of health problems.
 - Achieve a minimum of 95% referral completion rate for vision and hearing defects.
 - Administer medication according to law and school board policy.

Health Education

1. School nurse to serve as a resource person to elementary teachers and/or secondary health educators.
2. School nurse to conduct selected classroom sessions where appropriate.

School Environment

1. Survey school building and grounds for safety hazards.
2. Comply with government requirements/recommendations regarding food service, housekeeping, and maintenance.



Healthy Independent School District

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

Healthy, Texas

Goals for a School Health Program

1. To augment health instruction which guides students toward reaching full capacity as individuals who make responsible decisions about personal, family, and community health.
2. To advocate and help provide an environment conducive to the promotion and maintenance of health.
3. To detect and to provide nursing care for any physical condition which impedes learning or threatens optimum health. (Nursing care is defined as assessment, intervention, counseling, and/or referral of any physical conditions.)
4. To provide liaison among the school, home, community agencies, physicians, and other health personnel.
5. To provide a physical, mental, and emotional health advocate for children within the school.
6. To achieve acceptable levels of compliance with federal, state, and local health regulations.
7. To maintain and utilize current individual and collective health data.
8. To provide learning and growth experiences for staff members.
9. To evaluate the program's effectiveness.

Developing Policies

Section C-4.0

Texas Administrative Code §85.41 (see Sections C-4.1 and 4.2) lists 13 items in which districts must have written policies for school health service programs. These policies, along with others pertinent to individual districts, are invaluable for the planning and development of a program. Laws governing the practice of school health services, health education, and a healthful school environment are compiled in Section BB.

Professional organizations in the community particularly interested in health promotion, such as nursing, medical, dental, or optometry, may be of assistance in the initiation of policies.

TAC §85.41 and a clarification outline are provided in the following sections to assist districts in the compilation of school health program policies.

Texas Administrative Code (TAC) §85.41

Section C-4.1

Health Services Program

a) School health services shall be considered as part of the educational program of the school children of Texas. These services shall be provided to all children through local education agencies in accordance with the provisions of Subchapter D of Chapter 97 of this title (relating to Principles, Standards, and Procedures for the Accreditation of School Districts), and standards established by the Texas State Department of Health and in accordance with applicable laws. The local education agency shall ensure appropriate coordination of school health services, other student services, and related instructional programs.

b) School health services shall be addressed by policies of the local board of trustees. Local policies shall address the following functions:

1. planning, development, and evaluation;
2. health counseling;
3. screening;
 - (a) vision (Texas Civil Statutes, Article 4419f, and
 - (b) hearing;
4. prevention and control of communicable diseases;
 - (a) immunization (Texas Education Code §2.09); and
 - (b) exclusion and reporting of students or employees who have communicable diseases (Texas Civil Statutes, Article 4477);
5. provision for emergency cases;
6. consultation and coordination with other student services and related instructional programs to focus on the health-related needs of students and their families (including but not limited to special education and health education);
7. liaison with community health resources;
8. referral and follow-up to ensure that parents have been notified of identified problems and know how they can obtain needed services for their children;
9. health appraisals of students;
10. maintenance of pupil health records;
11. reporting child abuse (Texas Civil Statutes, Article 3401 et seq.);
12. administration of medication by school personnel (Texas Education Code §21.914); and
13. eye-injury reporting and eye-protective devices (Texas Education Code §21.909).

Issued in Austin, Texas on September 18, 1981.

Doc. No. 816665

Raymon L. Bynum, Commissioner of Education

Effective Date: October 9, 1981

Clarification Outline Texas Administrative Code §85.41

Section C-4.2

I. Planning, Development, and Evaluation:

In order to provide comprehensive school health and health maintenance services that comply with the accreditation standards, a school district must carefully plan, efficiently develop, and thoroughly evaluate the program. The school health program should be based upon an annual needs assessment. The program plan should address short and long-term goals and objectives.

Once the annual projection of student needs is made, the district must identify the resources for provision of the health program. A realistic school nurse/student ratio should be established. Consideration should be given to student needs and to health services planned. The goals and objectives of a school health program should be reviewed frequently for relevance and applicability to the individual school district.

The implementation of a school health program focuses on who will receive the services, how services will be provided, and who will provide the services. Districts must establish priorities for student services and organize time frames for screening schedules, referrals, and follow-up procedures. Recognition must be made for time allotment for student emergencies and illness, health counseling, health teaching, and health appraisals.

The evaluation provides a summation of the health program efforts. It points out areas where change is needed. An evaluation reveals strong and weak points. Evaluation results are helpful in planning continuing education or inservice programs.

Every phase of the school health program should be planned. The use of the principles and standards for accreditation provides guidance in establishing a priorities plan. The plan should:

- A. Express long-range and annual objectives for the school health program.
- B. Outline the major activities which are designed to achieve these objectives, and
- C. Define the ways and means by which progress will be determined.

The accreditation planning process further states:

If a plan is to serve as a guide for action, it must be clear to those responsible for its implementation. The plan must describe to its users: (1) the outcomes being sought, (2) the major activities to be carried out, (3) the roles of various staff members, (4) the target date or dates for completion, and (5) the ways in which progress will be determined. (see Section C-5.0)

II. Health Counseling:

Health counseling, a helping relationship designed to assist students and parents in meeting health care needs, consists of:

- A. Health maintenance, providing information and support in coping with illness and disability, and consumer options for making health care choice.
- B. Crisis intervention for situations involving drug abuse, child abuse, suicide threats or attempts, or other indications of acute stress.

Health counseling shall be provided to students identified through the health appraisal process, a referral by the principal, teacher, parent, self, or other school departments.

Health counseling implies a one-to-one communication between a health professional and a student, parent, or staff member. It generally centers around a child with a specific health problem (such as asthma, diabetes, or seizure activity), and includes a review of ways of adjusting student schedules. The distinction is made between health counseling and health education, in which groups of children receive general health information to assist in decision making. (see Sections E-7.0 and 8.0; F-1.0)

III. Screening:

A. Vision

The Texas Children's Vision Screening Act requires all children enrolling in school in Texas for the first time to submit within ninety (90) days after admission a certificate which states that the child has either (1) been examined by a physician licensed to practice in the United States or an optometrist licensed to practice in the United States, or (2) undergone a vision screening test which has been approved by the Texas Department of Health and which discloses the results of the examination or test. There is a provision for admittance upon submission of an affidavit signed by the parent that the child will undergo the required screening test or examination "as rapidly as feasible." Students who attend schools with on-going vision screening programs will not be required to present a certificate from a source outside the school system since there is a provision for the certificate to be signed by authorized school personnel, who have undergone special training. This became effective September 1, 1980. (see Section F-6.0)

B. Hearing

Hearing screening, while not mandated by law, is required by State Board of Education policy. It is necessary to determine the hearing status of students which may directly affect the learning process. Most school districts have been engaged in hearing screenings for several years. Districts are encouraged to arrange hearing screenings in concert with vision screenings, perhaps on alternating years. The Texas Department of Health provides instruction and registration of audiometric users (hearing screeners) and calibration checks of audiometers. (see Section F-7.0)

C. Other

The school nurse health appraisal traditionally includes assessment of dental status, nutritional and musculoskeletal status through measurement of height and weight, blood pressure, inspection of the skin and scalp, and a search for other visually discernable abnormalities such as scoliosis. (see Sections F-3.0, 4.0, 5.0, 8.0, and 9.0)

IV. Prevention and Control of Communicable Diseases

The school shall be responsible for maintaining immunization protection levels to reduce incidence of preventable diseases not amenable to immunization. Pediculosis and scalp ringworm screenings should be conducted for early identification and control. (see Section E-4.0)

A. Immunization (see Section BB-15.0 for detailed explanation)

Recent changes:

1. Mumps vaccine: At least one dose of mumps vaccine, or a history of mumps illness, validated in writing by a physician licensed to practice medicine in the United States, is required. Effective each September 1, this requirement must be met by students as designated. Age of the student is determined by age on September 1. See following table.

Mumps Immunization Requirements

Effective Dates	Age as of September 1
September 1, 1982	Thru 10 years
September 1, 1983	Thru 11 years
September 1, 1984	Thru 12 years
September 1, 1985	Thru 13 years
September 1, 1986	Thru 14 years
September 1, 1987	Thru 15 years
September 1, 1988	Thru 16 years
September 1, 1989	Thru 17 years
September 1, 1990	Thru 18 years and older

2. The requirements of Measles (Rubeola) immunization for all students was effective during the 1981-82 school year.

V. Provision for Emergency Cases

Well organized plans of action for the care of emergencies should be written by the district. An emergency ambulance telephone number should be known by building personnel and posted in conspicuous places. Schools should have readily available emergency information, provided by a parent/guardian, on each student. It is highly desirable that as many individuals as possible beyond health professionals be trained in first aid and cardiopulmonary resuscitation. (see Section E-3.0)

- VI. The school health program will utilize consultation and coordination of other student services and related instructional programs which focus on the health-related needs of students and their families; including, but not limited to, special education, health education, vocational or industrial arts education. (see Sections B, F, H, and AA)

VII. Liaison With Community Health Resources

Schools do not attempt to provide comprehensive nor primary health care, which is the responsibility of the parent. However, it is reasonable and cost effective to identify health barriers to learning and to assist with their correction or amelioration. In order to achieve this, community resources must be identified and good working relations established. This may best be done through a health advisory council composed of community health professionals, other professional groups, and parents. In addition to creating valuable links with health resources, this group may assist with formulating policies and procedures at the local level. (see Sections C-7.0 and AA)

VIII. Referral and Follow-Up

Following health screening, identified problems which may interfere with student learning will require attention to determine whether correction is possible. Primary responsibility lies with the parent, the family physician, and/or community health sources. School health professionals may assist the family in locating community resources for referrals. Follow-up implies a school nurse checking to ensure that the child did in fact see a physician or health care provider. Little is accomplished by appraisals and referrals unless a plan of work includes careful follow-up and recording of the findings, many of which may require an adjustment in the school environment.

IX. Health Appraisals of Students

Health appraisal of students by the school nurse may be: a formal individual physical exam including all body systems; mass screening processes; determining need for emergency or illness care; health counseling for health maintenance or crisis intervention; the administration of medication or providing special health care services; or any other contact with a student. Student health appraisal is an integral part and an on-going process of the entire school health program.

X. Maintenance of Student Health Records

Records in school health programs serve three primary purposes: administrative, medical, and educational. Administrative health records show which children have received mandated immunization, screenings, and examinations. Accident reports are also considered administrative records. Medical health records form the data base for medical care of individual children when the school assumes responsibility for health supervision of students. Clinical records include both positive and negative findings, growth charts, immunization procedures, and treatment plans. Educational health records indicate health-based recommendations for special management or observation of students while they are in the school. This information is needed for every school child regardless of responsibility of health supervision. (see Section CC)

XI. Reporting Child Abuse

"Any person having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect shall report in accordance with TEC §34.02. An individual reporting in good faith has protection from legal liability. Failure to report is punishable by fine and/or imprisonment." (see Sections E-7.0 and 7.1)

XII. Administration of Medication by School Personnel

A summary of the law includes these salient points. The board of trustees of each school district shall adopt policies concerning the administering of medication to students by employees of the district. These employees shall have immunity from civil liability from damages or injuries resulting from the administering of medication to a student if (1) the school district has received a written request to administer the medication from the parent, and (2) when administering prescription medication, medication appears to be in the original container and to be properly labeled. This should include the student's name and dosage directions. "Nothing herein should be construed to grant immunity from civil liability for injuries resulting from gross negligence." (Legal liability would be incurred if a school employee gave one child's medication to another child.) Records of medication administration during school hours should be kept, and indicate the time and the person administering the medication.

It is recommended that only medication *provided* by parents/guardians be dispensed by school personnel. (see Sections E-3.2 and BB-19.0)

XIII. Eye Injury Reporting and Protective Eye Devices

"Industrial quality eye protective devices shall be worn by every teacher and student in Texas participating in any of the following courses: vocational or industrial art shops or laboratories involving experience with (a) hot molten metals; (b) milling, sawing, turning, shaping, cutting, or stamping of any solid materials; (c) heat treatments, tempering, or kiln firing of any metal or other materials; (d) gas or electric arc welding; or (e) caustic or explosive materials; or (f) chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids. The governing boards and administrators of Texas school districts offering any of the listed courses are responsible for furnishing free of charge or providing at cost to teacher and students participating in the courses the required eye-protective devices."

Whenever an accident occurs during the conduct of any of the courses described and an injury to the eye of a teacher or student results, the principal shall make a full written report of the accident and injury to the Texas Education Agency. (see Section E-3.1 and BB-8.0)

Planning, Implementing, and Evaluating The School Health Program

Section C-5.0

One of the areas in which school districts must have a written policy is regarding the plan for providing a health program, including the implementation and evaluation. Planning should be directed toward both short and long term goals. Each person concerned with the school health program should have knowledge of its overall goal and the function of specific personnel.

It may be helpful for a district to make policy statements in very broad terms; goals in clear, concise, measurable statements; and extend these statements into specific action plans in a procedure manual.

Example

- Policy:** Healthy Independent School District will provide for emergency care of students and staff while at school or during school-sponsored activities until a parent or guardian may assume a student's care.
- Goal:** The goal of Healthy Independent School District is to provide emergency care for students or staff who become ill or injured while at school or during school-sponsored activities until a parent or guardian may assume a student's care.
- Procedure:** Healthy Independent School District will provide:
- Clinic facilities on each campus in accordance with the recommendations for "First Aid Facilities"—Texas Department of Health (provided in Section B-1.32).
 - Current emergency information cards on each student and staff member (see Section CC-4.0 for sample).
 - Emergency telephone numbers posted conspicuously and known to personnel.
 - Adequate amounts of first aid supplies.
 - Written emergency disaster plans and actions (see Section E-2.0).
 - Daily log notations of students seen in the clinic (see Section CC-1.0).
 - Annual evaluation of emergency care provided students and staff, including re-evaluation or adjustment of policy, goals, and procedures as needed.

A systematic, on-going approach for evaluation of the school health program includes procedures for collecting, analyzing, and interpreting data. Forms which may be helpful are a daily clinic log and a summative report on health services activities (see sample forms in Section CC). Revisions or re-evaluation of goals and procedures may be based on interpretation of data findings.

Four Basic Steps to the Evaluation Process

1. Define the program's goals and objectives.
2. Appraise the present program's progress.
3. Gather documentation of services provided.
4. Make recommendations regarding present and future program services (re-evaluation).

Organizational Chart

Section C-6.0

An organizational chart of the school district illustrates continuity of responsibility for the school health program. The chart may vary in detail according to the size of the district but should be provided for assistance to the new, as well as the experienced personnel. The following chart provides an example, presenting the student at the apex of a health program.

Section C-6.1

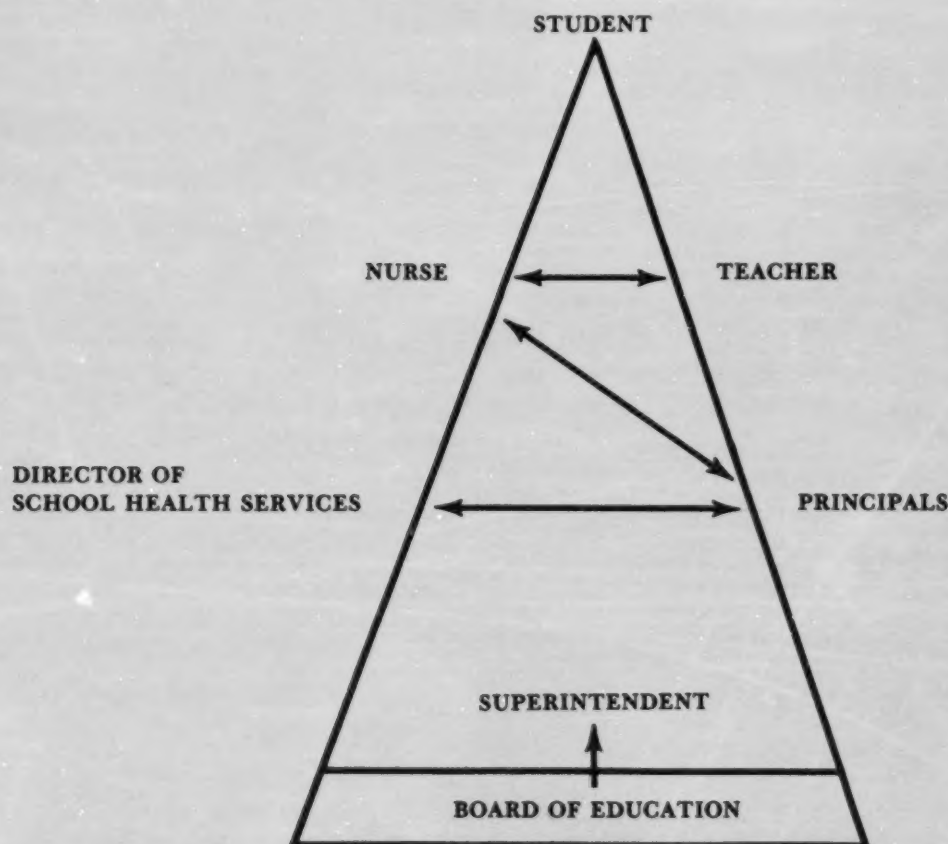


Healthy Independent School District

Healthy, Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

Organizational Chart for a School Health Program



Advisory Committee

Section C-7.0

Purpose

The School Health Program Advisory Committee should have one purpose: to help build and improve a strong district-wide health program.

Designed to provide close liaison between the schools and members of the local health professions, the committee would:

1. Provide school administrators with current information on health procedures and equipment.
2. Provide professional advice in designing and presenting effective instruction to students.
3. Assist in designing and conducting health screening procedures.
4. Promote a strong program of school-community relations in the health field.

Organization

A well-designed plan is essential for developing a productive advisory committee. This plan should include a strong, well-defined purpose for the group, for without it the committee will flounder and eventually collapse. Once the purpose has been defined, the following steps should be taken:

1. Draft a complete proposal, including the committee's purpose, suggested membership, long range goals and short term objectives, meetings schedule, and organization.
2. Present this proposal to the district superintendent.
3. Work cooperatively with the school district administration in drafting or implementing necessary changes in the plan.
4. Assist the superintendent in presenting the proposal to the board of education.
5. Implement the plan under the direction of the superintendent or his representative.

Membership

A well-planned and effective advisory committee should broaden the perspective of the school district staff. For this reason, prospective members should be selected both for knowledge of the health field and broad viewpoint concerning the needs of the public schools.

Professional members of the committee should be drawn from the nursing, medical, dental, and medical technology fields. Additional viewpoints would be brought by interested parents and members of other community groups. However, care should be taken to keep the committee small enough to be workable and effective. Advisory groups usually function best when membership ranges from five to 15 persons.

Operational Practices

The effectiveness of any advisory committee will depend on its sense of purpose, its own elected leadership, and the guidance it receives from the district. While operational practices will vary in detail with individual advisory committees, the following elements are common to most groups:

1. A clear definition of purpose should be prepared and presented both orally and in writing by the district representative assigned to work with the committee.
2. An outline of the district's plans for health services and related activities should be presented by the superintendent or a top level representative.
3. Specific tasks or objectives related to these plans should be presented to the committee, along with a suggested time line or schedule.

4. A program of work, including individual responsibilities of members, should be planned and implemented under the leadership of the committee's elected chairman.
5. Reports of progress based on committee recommendations should be presented by the district liaison staff member on a regular basis. If any recommendation is not implemented, the committee should also be told the reasons and be given suggestions for possible new directions.

Organization

Strong leadership is essential for any committee or group of people to function as a unit. For this reason, the original membership roster must include individuals with both professional knowledge and the ability to work effectively as group leaders. Each committee should include:

1. Elected officers, probably including chairman, vice chairman, and secretary.
2. Stated terms of service for members.
3. Procedures for establishing subcommittees.
4. Provisions for compiling committee minutes, setting schedules.
5. Procedures for replacing members.

Section C-7.1



Healthy Independent School District

Healthy, Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Health Program Advisory Committee Statement of Purposes (Charter)

The Board of Education of HEALTHY INDEPENDENT SCHOOL DISTRICT authorizes the establishment of the HEALTHY INDEPENDENT SCHOOL DISTRICT School Health Program Advisory Committee on this

_____ day of _____, _____. The function of the HEALTHY INDEPENDENT SCHOOL DISTRICT School Health Program Advisory Committee is to provide advice and counsel to the nursing and administrative staff of the School Health Program. It is not given authority for policy decisions, and is expected to operate within the guidelines set forth.

The purpose of the School Health Program Advisory Committee is to contribute to the improvement of health services, health education, and a healthy school environment in the HEALTHY INDEPENDENT SCHOOL DISTRICT through such functions as:

- verifying the need for health instruction, screenings, and procedures;
- providing input on staff, equipment, and facilities that is both current and relevant to the school child's needs; and
- promoting community public relations.

_____, Chairman

_____, Superintendent

Section D

School Nursing Services

- | | |
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| Section D | School Nursing Services |
| | 1.0 Personnel |
| | 1.1 Nurse Administrators |
| | 1.2 School Nurse Practitioners |
| | 1.3 Staff Nurses |
| | 1.4 Nurse Extenders |
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Personnel

Section D-1.0

Nurses are professionals who may be most helpful in the promotion of good health for the entire school community. Research and practice indicate that a registered nurse to student ratio of 1:1000 or less is needed to provide quality care for students. Districts are encouraged to work toward a staffing level that will assure optimal care in the provision of health services.

It is suggested that the school nurse function in one of the following capacities, based on professional preparation: nurse administrator, nurse practitioner, or staff nurse. In organizations of two or more nurses, a coordinator should be appointed. Nurse-extenders such as vocational nurses, nurse aides, and volunteers may also be of assistance.

The school nurse is a registered professional nurse with or without a baccalaureate degree. Certification by the Texas Education Agency is not currently required but is available under the Texas Education Agency Requirements for School Nurse Certification.

Responsibility for the school health program lies with the district administration. Direct operation is usually delegated to the school nurse. In larger school districts, the nurse may serve as a manager, referring tasks to persons with specific training. In smaller districts, the nurse may provide all the services. For the sake of clarity, "school nurse responsibilities" are defined globally; local districts must decide which duties may be designated.

All school nurses are reminded to include the title "R.N." with signatures and to wear insignia identifying this title.

Texas Statutes Regulating the Practice of Professional Nursing, as amended, 1981. Board of Nurse Examiners for the State of Texas, Austin, Texas; Article 4522. Use of Title "R.N."; Registration Bureaus:

"A nurse who has received his or her license according to the provisions of this law, shall be styled a "Registered Nurse," and may use the title or abbreviation "R.N." When a licensed registered nurse is on duty providing direct care to patients, the nurse shall wear an insignia identifying the nurse as a registered nurse."

Nurse Administrators

Section D-1.1

The nurse administrators are responsible for the organization and delivery of a comprehensive and effective school health program. The American Nurses Association, Commission on Nursing Services, distinguishes three levels and responsibilities of nurse administrators.

Executive Level

Responsibilities of the nurse administrators include:

1. Participating in the administration of the total health care agency.
2. Determining clinical and administrative goals and directions of the nursing department.
3. Devising departmental functions and activities to achieve goals.
4. Acquiring and allocating resources for the determined functions and activities.
5. Evaluating and revising the organizational goals, structures, activities, and resources of the nursing department.
6. Providing leadership in problem solving.
7. Providing leadership in human resources development and personnel management.
8. Providing channels for consumer input into policy development.

Middle Level

Responsibilities of middle administrators may include:

1. Participating in nursing policy formulation and decision making.
2. Problem solving and supervising the delivery of nursing care.
3. Evaluating care provided.
4. Collaborating with other departments.
5. Coordinating staff activities.
6. Staffing and scheduling of personnel.
7. Arranging for equipment and supplies.
8. Recruiting and selecting personnel.
9. Evaluating staff for promotions and transfers, disciplinary action, and separation of service.
10. Providing orientation, training, and continuing education for staff.
11. Undertaking or facilitating research activities.
12. Providing and coordinating clinical learning experiences for students.

First-Line Level

Responsibilities of first-line administrators typically include:

1. Providing for direct nursing care services to clients.
2. Evaluating nursing care given and assuring appropriate documentation, guidance, and supervision of staff members.
3. Selecting nursing personnel for hire.
4. Evaluating staff, including disciplinary action and separation from service.
5. Providing for teaching and staff development.
6. Coordinating nursing care with other health services.
7. Participating in and involving staff in nursing research.
8. Providing clinical facilities and learning experiences for students.

School Nurse Practitioners**Section D-1.2****Criteria**

- Education: registered professional nurse with academic preparation at baccalaureate or higher level
- Certification: School Nurse Practitioner
- Experience: number of years to be established by individual school district

Functions

- Perform physical examination in the following situations:
 - Students needing physical examination for special services.
 - Students needing physical examinations as a prerequisite to participation in athletic programs.
 - Students needing a total assessment to determine possible health barriers to learning.
- School nurse practitioners will be able to:
 - Serve as health advocates for the child.
 - Identify the health status of the child by securing and evaluating a thorough health, developmental, and social history from the parent. Recording of data must be succinct and systematic.
 - Develop individual plans of care and management for health, behavior, and learning problems which may include appropriate referrals and interdisciplinary planning.
 - Interpret student health status with teachers and other school personnel, and provide guidance regarding adjustments and management of educational and health programs for students.
 - Perform developmental evaluations and appropriate screening tests; initiate and participate with other health and educational professionals in assessing normal variations and abnormalities of motor, cognitive, and perceptual aspects of child development.
 - Assist in determining the presence of significant emotional disturbances and psychoeducational problems of childhood and adolescence.
 - Participate in developing and coordinating health care plans involving child, family, school, and community to enhance the quality of health care and to diminish fragmentation and duplication of services.
 - Participate in the implementation of the health education curriculum.
 - Provide health education to individuals and groups; apply methods designed to increase each person's motivation and ability to assume responsibility for own health care.
 - Participate in peer review of school nurse practitioner practice.
 - Document and evaluate individual school nurse practitioner practice on a continuing basis for administrative and policy purposes.
 - Assist in the implementation of federal laws which affect the health, well-being, and educational planning of the school aged child.
 - Establish and maintain a professional liaison with a specified physician for consultation service.

Staff Nurses**Section D-1.3**

Staff nurses will perform appropriate actions to implement the guidelines for the school health program as outlined in the Texas Administrative Code §85.41 (see Section BB).

Continuing education and professional growth should be an integral part of planning by the individual school nurse and by the administrators of the school health program. Staff nurses may elect to move toward the professional goal of the expanded role of a school nurse practitioner.

Criteria

- Education: registered professional nurse with academic preparation at the diploma, associate degree, or baccalaureate level; current Texas license issued by Board of Nurse Examiners.
- Certification: see Section D-2.0
- Experience: Applicant from two year or three year programs should have supplemented basic preparation with a minimum of two years supervised nurse practice prior to entry into school nursing, preferably in Community Health.

Functions

- Serve as a health advocate for the child.
- Assess student health needs.
- Assume responsibility for management and planning for acute, chronic, and emergency health problems including appropriate referral and follow-through.
- Provide relevant counseling and guidance to assist children and parents in assuming responsibility for health maintenance of the child.
- Assist in communicable disease control through implementation of programs for student immunization, management of suspected and diagnosed cases of infectious disease, detection and control of pediculosis, scalp ringworm, impetigo and other scalp and skin conditions, and through venereal disease control information and referrals.
- Possess full range of knowledge and skills in health appraisals for identifying student health defects.
- Maintain accurate updated records of health information on all students, and make provisions for timely and accurate management of incoming and outgoing records and reports.
- Initiate referral and follow-up relevant to unmet health needs of students, and make appropriate interpretation and distribution of health information to facilitate identification of educational needs of students.
- Coordinate health service activities with the instructional program.
- Work with parents and with medical and health care community to promote optimum delivery of health care services to students.
- Anticipate supply and equipment needs appropriate to maintaining a continuous functional building level program.
- Participate in faculty activities.
- Allocate appropriate job functions and assume responsibility for supervision of nurse-extenders.

Nurse Extenders**Section D-1.4**

Nurse extenders, such as licensed vocational nurses, nurse aides, or volunteers, are non-professional employees with technical skills. Extenders may provide vital assistance to the school nurse by assuming routine record keeping activities and minor first aid.

There are selected activities and responsibilities which the nurse extender may fulfill to the benefit of the school health program. Nurse extenders are analogous to teacher aides and should not be expected to provide primary health service.

Licensed Vocational Nurse and/or Nurse Aide**Section D-1.41****Criteria**

- Education: high school graduate or GED
- Certification: Texas Education Agency paraprofessional
- LVN: current Texas license issued by the Board of Vocational Nurse Examiners
- Experience: Suggested is a minimum of one year's experience in some phase of community health, which includes contact with school-age children. A basic first aid course and cardiopulmonary resuscitation course should be acquired.

Functions

- Work under the immediate guidance and supervision of the school nurse.
- Has no responsibility as the sole health program provider, and should not be asked to provide health teaching, planning, nor implementing of the school health program.
- Assist with screening activities such as height/weight, vision, hearing, or scalp. All vision and hearing screeners must comply with Texas Department of Health requirements for tester training.
- Fulfill task-oriented role dealing with record keeping and paperwork.

Volunteer/Adult and Student Assistant**Section D-1.42**

The adult volunteer and the student assistant function in a nurse-supervised team structure. Task-oriented functions assigned by the nurse may be in keeping with the wide range of background knowledge and skills represented by persons serving in this capacity.

The Red Cross "Health Room Volunteer Program" is an example of a formal preparation that may be provided for volunteers. Orientation and continuing education for the volunteer is essential.

Adult and student volunteers should not have access to student records.

School Nurse Certification Texas Education Agency

Section D-2.0

A school nurse is not required to hold a Texas School Nurse certificate. However, the following Texas Education Agency certification is available.

1. Requirements for Provisional Certification of School Nurse with Bachelor's Degree:
 - a. bachelor's degree
 - b. current registration with Texas State Board of Nurse Examiners
 - c. satisfactory completion of course or certification examinations in federal and Texas constitutions
 - d. satisfactory completion of six semester hours in American History
 - e. submission of application with official transcripts showing a bachelor's degree conferred, photostatic copy of current registration with the State Board of Nurse Examiners, and \$10.00 fee (money order or cashier's check) to the Division of Teacher Certification
2. Requirements for Provisional Certification for Non-Degreed Registered Nurses:
 - a. current registration with Texas State Board of Nurse Examiners
 - b. satisfactory completion of course(s) or certification examination(s) in federal and Texas constitutions
 - c. submission of an application with official transcript or examination score, photostatic copy of current registration with the State Board of Nurse Examiners, \$10.00 fee (money order or cashier's check) to the Division of Teacher Certification
3. An individual who has a current registration with Texas State Board of Nurse Examiners may be employed in a school district as a school nurse without a provisional certificate.

School Nurse Evaluation

Section D-3.0

The primary objective of school nursing services is to strengthen the educational process through the school health program. It is imperative that nursing responsibilities in the promotion and preservation of optimum health be established, competencies and professional growth be provided through staff development, and evaluation guidelines be written and understood.

School nurses are included in TEC §21.201, provided in Section BB-7.0, and defined as "Teacher means . . . full-time professional employee and are to be evaluated annually." Additionally, evaluation is addressed in TEC §21.913 outlining the "Duties of Public School Principal."

- (a) Public school principals, who shall hold valid administrative certificates, shall be responsible for:
 - (1) assuming administrative responsibility and instructional leadership, under the supervision of the superintendent, for discipline, and the planning, operation, supervision, and evaluation of the educational program of the membership area in which he is assigned;
 - (2) submitting recommendations to the superintendent concerning assignment, evaluation, promotion, and dismissal of all personnel assigned to the membership center; and
 - (3) performing any other duties assigned by the superintendent pursuant to school board policy.
- (b) Nothing herein shall be construed as a limitation on the powers, responsibilities, and obligations of the school board as now prescribed by law.

Two school nurse evaluation samples are provided in the following sections, D-3.1 and D-3.2. School districts are encouraged to make additions or deletions to these instruments to meet specific needs.



Section D-3.1

Healthy Independent School District

Healthy, Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Nurse Evaluation Form (Sample 1)

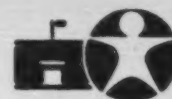
- *O = Outstanding— Performance as observed is consistently exceptional and is worthy of special recognition.
- C = Competent— Performance as observed is professionally competent and meets expectations of HISD.
- N = Needs Improvement— Performance as observed indicates a need for continued growth and improvement is expected.
- *U = Unacceptable— Performance as observed does not meet the standards of HISD and improvement is mandatory.

*Comments must be recorded.

Performance Competencies	O	C	N	U	Comments
1.00 Personal-Professional Characteristics					
1.01 Fulfills professional role expectations with minimal personal interest/family conflict.					
1.02 Reflects professional leadership abilities in responsible self directed goal setting, decision making, and action taking activities.					
1.03 Exercises professional judgment in absences from work.					
1.04 Participates in self-directed continuing learning activities in acquiring new skills and knowledge for upgrading school nursing.					
2.00 Health Clinic Management					
2.01 Maintains a safe, orderly, and attractive work area with appropriate emotional and physical environment.					
2.02 Develops a program that assures safe ongoing emergency health care.					
2.03 Anticipates supply and equipment needs for maintaining and continuous school health program.					
2.04 Develops a complete and functioning health program through maximum utilization of existing facilities.					
2.05 Plans for communication with principals and faculties to provide a health program with minimal interruption to total building schedule.					
2.06 Maintains accurate and current health information on all students to insure the timely management of incoming and outgoing records and reports.					
2.07 Initiates referrals and follow-up relevant to the unmet health needs.					
2.08 Makes appropriate distribution of health information to facilitate recommended changes in academic schedules.					
3.00 Interacting With Students					
3.01 Provides opportunities for developing self-evaluation skills which aid the student in setting realistic goals and understanding himself, his strengths, and his limitations.					
3.02 Assists the student in accepting responsibility for his actions.					



Performance Competencies	O	C	N	U	Comments
3.03 Demonstrates respect for students by showing tolerance for students whose ideas differ; using supportive criticism rather than blame, shame, or sarcasm; encouraging students to respect the rights of others; being fair, impartial and objective in the treatment of students.					
3.04 Provides opportunities for all students to experience success by recognizing the special needs of students.					
3.05 Utilizes appropriate district services available to benefit the student.					
3.06 Sets an example of, and encourages, socially acceptable behavior.					
3.07 Maintains an atmosphere conducive to freedom of thought and expression and shows respect for pupil opinions and suggestions.					
3.08 Readily available to students for counseling and individual help.					
4.00 Professional Attitude and Conduct					
4.01 Shows an honest, caring attitude that invites student trust.					
4.02 Demonstrates the ability to see student as a total person rather than a physical, educational or social problem.					
4.03 Uses resourcefulness and skill in helping students with health maintenance needs and with management of health problems.					
4.04 Respects the need to treat personal health problems as a very private affair.					
5.00 Skills and Knowledge					
5.01 Demonstrates knowledge and skills in health appraisal techniques.					
5.02 Utilizes appropriate resources within the community to promote delivery of health care services.					
5.03 Serves as a leader in school community activities for communicable disease control, preschool health screening, health room volunteer services, etc.					
5.04 Demonstrates a sensitivity to students' need to be heard as well as helped by health counseling.					
5.05 Interprets and uses health information with good judgement.					
5.06 Helps students and parents in exploring alternate approaches to meeting health care needs.					
5.07 Provides a helping relationship with individuals or families in crises intervention.					
5.08 Participates in teacher-nurse-family conferences at appropriate times to consider the physical, emotional, and social health of each child.					
6.00 Health Education Skills					
6.01 Uses health services activities as a vehicle for direct and indirect health teaching.					
6.02 Serves as a resource person to the school staff in special areas of expertise.					
6.03 Involves appropriate resource persons from the health-medical community in the educational process.					
6.04 Provide learning experiences to equip students to make constructive decisions regarding health behavior.					
6.05 Serves as an extension to career education efforts through participation in the area of health career guidance.					



Performance Competencies	O	C	N	U	Comments
7.00 Interacting With Parents and Community					
7.01 Contributes to establishing and maintaining a positive school-community relationship.					
7.02 Participates in an active role with health, welfare, and community activities.					
7.03 Conducts the school health program in a manner that elicits positive support from students, parents, school and community.					
7.04 Communicates an interest in community health through creative participation.					
7.05 Recognizes that the parent is an extension of the school health program and invites parental involvement in planning health care.					
8.00 Appearance and Health					
8.01 Keeps grooming and personal attire appropriate to professional health services practice.					
8.02 Increases the positive image of school health programs through the practice of good health habits.					
8.03 Maintains stability and poise in student, parent and peer group relationships.					
8.04 Demonstrates enthusiasm and vitality in the performance of duties.					



Healthy Independent School District

Healthy, Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Nurse Evaluation Form (Sample 2)

Rating Scale for Evaluation:

Unacceptable		Acceptable		Outstanding	
0	35	36	61	62	81

0 - 35: Unacceptable
 36 - 61: Acceptable
 62 - 81: Outstanding

Breakdown of Areas of School Nurse Competencies And Value for Each Performance Descriptor:

Area of School Nurse Competence	Unacceptable	Acceptable	Outstanding
	Competencies Performed	Competencies Performed	Competencies Performed
#1	1-8	9-11	12-13
#2	1-10	11-14	15-17
#3	1-3	4-5	6-7
#4	1	2-4	5-6
#5	1-4	5-7	8-10
#6	1-4	5-7	8-9
#7	1-2	3-5	6-7
#8	1	2	3-4
#9	1	2-3	4
#10	1	2-3	4



School Nurse Evaluation Form

#1: Responsibility to the School Staff

The school nurse is an essential member of the professional staff employed to assist in the implementation of the basic goals of education. As a professional staff member, the nurse:

- Implements the school health program and practices in accordance with the school district's philosophy of education.
- Adapts the guidelines, as stated in the district's school nurse policy and procedure book, to the needs of the students, staff, and community.
- Serves as a contributing member on a committee to establish or revise school district policies.
- Implements and is knowledgeable of applicable state and county school laws, regulations, and recommendations.
- Discusses school health legal provisions with the school principal.
- Establishes a channel to communicate health trends and problems to the school principal and faculty.
- Keeps abreast of current developments within the total school district program.
- Explains to parents the school and district educational philosophy.
- Actively participates in faculty meetings and serves on faculty committees.
- Regularly attends parent-teacher association meetings and participates in activities.
- Establishes an effective relationship with all school personnel.
- Submits reports to the appropriate personnel on time.
- Creates a climate which encourages staff members to seek the nurse's counsel.

#2: Health Appraisal

Health appraisal is the sum total of all diagnoses and observations made concerning the health status of the school child. The school nurse:

- Plans and implements health assessment and screening programs with assistance from school personnel and parent groups.
- Sets priorities as to which student will be appraised.
- Schedules the frequency of health assessments necessary for the school.
- Conducts screening programs such as:
 - Communicable disease
 - Vision
 - Hearing
 - Dental
 - Special (Laboratory)
 - Scoliosis
 - Hypertension
 - Physical fitness
 - Other
- Provides information to parents and school personnel that will assist with evaluation of students' health needs.
- Records data from health assessment, screening programs, corrections, and follow-up procedures on forms approved for use in the school.

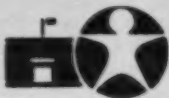


- Utilizes information gathered from the health assessment and screening programs to:
 - Identify health problems.
 - Interpret rules and regulations in regard to conditions under which students are excluded and readmitted to school.
 - Serve as a resource for health education curricula.
- Assists parents in obtaining professional services for children needing corrections.
- Interprets and/or reinforces through counseling procedures with student and parent, the physician's findings and recommendations.
- Utilizes community, state, and national resources in referral of health problems.
- Utilizes a system of periodic review and supervision of all students' health status.
- Develops and utilizes a variety of instruments suitable for review by the nurse, student, teacher, and parent as follows:
 - Observation
 - Interviews and conferences
 - Questionnaires
 - Checklists
 - Surveys
 - Records
 - Reports
 - Tests
- Records corrections, notes on referrals, health counseling, and follow-up procedures.
- Files all health records to be available for future use.
- Submits reports of health assessment and screening programs to supervisory staff and principal.
- Reviews stated aims and objectives of the health appraisal and screening program to determine if these have been accomplished.
- Revises as needed the current health assessment and screening program.

#3: Health Counseling

Health counseling is an essential part of school nursing services. The school nurse:

- Establishes and implements methods of identifying students and families who need health counseling.
- Plans and schedules health counseling sessions for individuals and groups.
- Utilizes each opportunity to do circumstance-oriented health counseling.
- Obtains all information from appropriate personnel and records prior to health counseling sessions.
- Informs appropriate personnel of counseling progress.
- Utilizes all appropriate school and community services to effect necessary behavioral change of students and families.
- Periodically reviews the progress of counseling.

**#4: Special Education Program**

The school nurse's specialized knowledge enables the nurse to assist in planning educational services appropriate for students whose physical, mental, and social deviations have educationally significant dimensions. The school nurse:

- Assists teachers in identifying candidates for possible placement in special programs.
- Follows school district procedures to secure all necessary data needed for evaluation of candidates for admission or dismissal.
- Conveys the philosophy of special education to students and parents during health counseling sessions.
- Participates in re-evaluation of students in special education each year.
- Recommends modification in the health education program to the special education teachers to meet the needs of the students.
- Conducts inservice education programs indicated by the number and types of referrals from the school personnel.

#5: Communicable Disease Prevention and Control Program

The school nurse holds the primary responsibility for implementing the control of communicable disease in the school for the protection of all students and school personnel, in compliance with the rules and regulations established by the local and state health departments. The school nurse:

- Maintains and monitors students' immunization records to ensure compliance with communicable disease laws, regulations, and policies of the State and local school district.
- Interprets these laws, regulations, and policies to the parents and students.
- Cooperates with local health department in conducting communicable disease control program.
- Assists teachers in developing a unit on communicable disease.
- Makes specific recommendations to appropriate persons, i.e., possible need for tetanus booster following injury.
- Assists in enforcing policies for the control of communicable disease for students and school personnel by:
 - Exclusion
 - Readmission
 - Classroom inspection when necessary
 - Reporting to health department if necessary
- Communicates with faculty regarding current communicable disease problems.
- Plans, organizes, and assists with the control programs when necessary.
- Supervises the reporting of all animal bites to the appropriate official agency.
- Identifies signs and symptoms of communicable diseases present in the community.

#6: Environmental Health and Accident Prevention

The school nurse is the key person in ascertaining problem areas and channeling information to the appropriate authority for evaluation and corrective action. The school nurse:

- Inspects school plant at periodic intervals for environmental health problems and reports such problems to the appropriate person.



- Complies with first aid guidelines when administering first aid and emergency care.
- Attends periodic first aid refresher courses.
- Provides first aid supplies.
- Plans with the building administrator for emergency care.
- Provides emergency care instruction to school personnel.
- Reports accidents to appropriate personnel for corrective action.
- Analyzes the compiled statistical reports to determine causes and location of accidents.
- Initiates safety programs:
 - As results of above reports
 - Preventive

#7: Health Education

Health education includes all information relating to health in the home, school, and community. Functional health education must be more than a subject in the curriculum. It must be action-centered and behavior-changing if it is to serve the needs of students. It is impossible to separate health education from health service. The school nurse is involved in instruction as a health specialist. The school nurse often:

- Serves on a curriculum development committee as a health specialist.
- Accepts invitations from teachers to participate in classroom activities as a health resource person for a variety of topics.
- Disseminates current and scientifically accurate health education materials and information to teachers.
- Compiles profile of current school and community health problems to be used in determining health curriculum content.
- Reviews with appropriate personnel current publications and other media being considered for use in the curriculum.
- Serves as resource speaker and consultant at PTA, parent education meetings, discussion groups in special interest areas, and pre-school orientation.
- Utilizes opportunities to informally share with parents health information which will effect positive attitudes and behavior.

#8: School-Community Health Program

The school nurse should exercise leadership in assuring that the school health program is an integral part of the community health program. The school nurse:

- Promotes communication between the community health professionals and the school.
- Maintains current files of community resources.
- Utilizes the services of health or community agencies.
- Participates in the implementation of community health programs.

**#9: School Nursing Service Evaluation Program**

Program evaluation should be designed to reveal both strengths and weaknesses in the school nursing service program. It should reveal existing opportunities for more effective procedures and practices; and it should provide data which can be used to revise specific objectives, improve methods and materials, and develop new learning experiences. The school nurse:

- Compiles and analyzes school health department records, reports, and statistical information at least twice yearly.
- Plans and implements action (projects) research as needed to improve the school nurse service program.
- Reviews published research and applies findings if appropriate.
- Conducts self-evaluation yearly using a professionally prepared instrument.

#10: Responsibility to the Profession

School nursing is unique in that it requires skills and knowledge derived from two professions, nursing and education. The school nurse serves as a faculty member with the same obligations as other teachers to participate in activities of the education profession. The school nurse :

- Joins and participates in activities of school nurse and teacher professional organization.
- Sustains current health knowledge and trends by:
 - Reading professional literature
 - Attending lectures or workshops
- Attends and participates in school and community activities.
- Informs students regarding career opportunities in health professions at the end of each unit of health.

Section E

Responsibility of the School Nurse

- | | |
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| Section E | Responsibility of the School Nurse |
| | 1.0 National Association of School Nurses, Statement |
| | 2.0 Disaster Guidelines |
| | 3.0 Emergency and Illness Care |
| | 3.1 Report of Eye Injury |
| | 3.2 Recommendation Regarding Medication |
| | 4.0 Communicable Disease Control |
| | 4.1 Communicable Disease Chart |
| | 5.0 Immunizations |
| | 5.1 Sample 1: Key punch Form |
| | 5.2 Sample 2: Key punch Form |
| | 5.3 Suggested Schedule for Routine Immunizations—Texas Department of Health |
| | 5.4 Annual Report of Immunization Status Form |
| | 5.5 Personal Immunization Record |
| | 6.0 Reportable Diseases of Texas |
| | 6.1 Reportable Diseases of Texas (List) |
| | 7.0 Child Abuse |
| | 7.1 Report of Child Abuse or Neglect |
| | 8.0 Suicide |
| | 8.1 Facts and Fables on Suicide |
| | 8.2 Warning Signs of Suicide |

**National Association
Of School Nurses, Statement
The School Nurse Services Program**

Section E-1.0

GOAL: To strengthen the educational process through improvement of the health status and learning of children and youth.

I. Responsibility to the School Staff

GOAL: To function as a contributing member of the school staff in all aspects of the school program.

II. Health Assessment

GOAL: To assess and evaluate the total health and developmental status of each student through nursing assessment and the use of appropriate evaluative techniques.

III. Medication in the Schools

GOAL: To assure the school attendance for children who must use medication in the treatment of chronic disabilities or illness.

IV. Health Counseling

GOAL: To assist students, parents, and teachers to obtain optimum wellness by stimulating behavior change through individual and group health counseling.

V. Special Education Responsibilities

GOAL: To assist in the appropriate placement of students with exceptional needs.

VI. Responsibilities to Students with Chronic Health Problems

GOAL: To assist students, parents, and teachers to adapt to students' chronic health problems.

VII. Responsibilities to Students With Special Needs

GOAL: To protect the well-being of children and youth.

VIII. Responsibilities Related to Nutrition of Students

GOAL: To assure a well-nourished school population.

IX. Prevention and Control of Communicable Disease

GOAL: To protect the well-being of students.

X. Emergency Care Responsibilities

GOAL: To set and maintain standards of emergency care to minimize the effects of accidents and illness in the school.

XI. Health Instruction

GOAL: To assure that each student will be a health-educated person and a knowledgeable health consumer.

XII. Nurse Practitioner in the Schools

GOAL: To provide quality indepth physical assessment to students and to improve the delivery of health care.

XIII. School Health Liaison to Community Agencies and Medical Care Facilities

GOAL: To assure that the health needs of the school population are considered in the community's overall health planning.

XIV. Research

GOAL: To improve the School Nursing Service Program.

XV. Program Evaluation

GOAL: To improve the School Nursing Services and Educational Programs.

XVI. Responsibilities to the Profession of School Nursing

GOAL: To contribute to the improvement of the profession and to maintain personal professional competence.

Disaster Guidelines

Section E-2.0

The building principal is directly responsible for emergency care of students and employees in the event of a disaster. Students and staff should be familiar with disaster plans through well organized and practiced drills. The school nurse or a principal's designee will provide care of the ill and/or injured following a disaster until students may be released to the care of parents/guardians.

Disaster Nursing

The school nurse or a principal's designee will immediately—by telephone, short wave radio, or whatever means available—notify an immediate supervisor who will alert other persons and agencies needed. All emergency and rescue efforts are coordinated through the local chapter of the American Red Cross and the local Civil Defense headquarters. Follow-up reports are made by the nurse as the situation develops or is further assessed.

The on-site nurse in charge may be required to assist in setting up shelters, emergency aid stations, temporary infirmaries, and morgues.

Nurse Responsibilities

- Establish nursing care priorities.
- Plan for adequate emergency communication and transportation; request additional professional personnel.
- Assign nurses and other health service personnel to appropriate duties.
- Set up a triage station.
- Arrange for necessary medical and nursing supplies.
- Arrange for appropriate transfer or referral of patients to follow-up health care and other facilities.
- Maintain records of patients treated, referred, or transferred.
- Maintain adequate sanitation.
- Exercise professional judgement at all times.
- See that all persons seeking care are received with genuine reassurance, given prompt treatment, and understand any instructions for continuing treatment.

Emergency and Illness Care

Section E-3.0

Each school district should have comprehensive, written emergency and illness care policies. The policies should be approved by school administration, board of trustees, and nurse(s). Policies should be stated in a procedure manual. The school is responsible for the immediate handling of accidents and sudden illness occurring on school property or during school sponsored activities. The school is not responsible for treatment or medical expense incurred after the administration of first aid.

Recommendations

- Emergency cards should include: telephone numbers where parent/guardians may be reached during the day; other persons in the community to be called if parents cannot be located; local physician's name and telephone number; local hospital preference; any medical problems or drug allergies which the student may have; and a parental signature. (see Section CC-4.0)
- The nurse and/or other designated school personnel, with the emergency card, accompany the student to the hospital and remain until the parent/guardian assumes responsibility. If a private car is used, two adults should be assigned, allowing one person to attend the student.
- Ambulance, police, fire departments, and poison control center phone numbers should be posted conspicuously and reviewed annually with staff members.
- Arrangements should be made, in cooperation with the principal, for another qualified person to administer first aid in the nurse's absence.
- The school should provide a health room/clinic and appropriate first aid supplies.
- First aid in the schools should be administered in accordance with accepted procedures, such as those of the American Red Cross. A current first aid manual should be kept in the health room/clinic for quick reference.
- The school nurse should be qualified as a certified First Aid and Cardiopulmonary Resuscitation Instructor. First aid and CPR classes should be offered to school personnel and students on a regular schedule.
- All first aid procedures should be reviewed annually.
- All *animal* bites should be reported to the proper authorities after emergency care is given (see Section CC-7.0).
- All incidents involving a *head injury* should be carefully documented. A parent/guardian of the student sustaining the head injury should be notified immediately. Head injury symptoms may not manifest at once, and parents must be made aware of later evolving signs and symptoms (see Section CC-6.0).
- All shop or lab-related incidents involving *eye injury* to student or personnel must be reported to the building principal. The "Report of Eye Injury" form, TEA ADM-062R81, follows (see Section E-3.1).
- All medication must be administered within the guidelines of TEC §21.914, included in Section BB.

Section E-3.1

District Name _____

TEXAS EDUCATION AGENCY
Division of Curriculum Development
Report of Eye Injury

Co.-Dist. # _____

School Name _____

Authority for Data Collection: Texas Education Code, Section 21.909 part (d)**Planned Use of the Data:** Establish preventive standards for schools, and development of safety education curriculum.**Instructions:** Please prepare within five days of the eye injury and forward to the Texas Education Agency. Contact Glenn Peavy at (512) 475-2608 if further clarification is needed.

1. Name of injured _____
() Pupil
() Teacher
() Other (_____).
2. Sex _____ Age _____ Grade or Position _____
3. Date of Accident _____ Time of Day _____
4. Time lost Due to Accident _____
5. Location of Accident: School _____ Facility _____
6. Course Being Taught _____
7. Activity in Class _____
8. Was Activity Supervised? _____ Yes _____ No
9. Name of Supervisor or Teacher _____
10. Nature and Extent of Injury _____

11. Cause of Accident _____
12. Were Protective Eye Devices Worn? _____ Yes _____ No

Typed Name of Authorized School Official	Telephone	Date

Signature of Authorized School Official _____

Return completed report to:
Texas Education Agency
Safety & Driver Education
Division of Curriculum Development
201 East 11th Street
Austin, Texas 78701

ADM-062R81

Recommendation Regarding Medication

Section E-3.2

It is recommended that school districts *not provide* any medication for students or personnel. Only medication provided by and requested by a parent/guardian should be dispensed.

If medication is provided, school districts and school nurses will be in the position of not only "diagnosing and prescribing," but also in "dispensing" medication for which neither is licensed.

"Medication" is recognized as prescription as well as nonprescription drugs and includes, but is not limited to: analgesics, antipyretics, antacids, antibiotic ointments, antihistamines, decongestants, or cough/cold preparations.

Communicable Disease Control

Section E-4.0

The school nurse should assume a leadership role in establishing a communicable disease control program in the school. The nurse works with the superintendent, principal, and teachers to develop written recommendations concerning:

- Exclusion and readmission of children with suspected communicable disease.
- Enforcement of the statutes regarding immunization for school attendance.
- Establishment of policies for handling children suspected of having communicable diseases.
- Investigation to determine whether the school is the source of epidemics of communicable diseases.

The nurse should be aware of all current communicable disease regulations. If the nurse is not in the school on a daily basis, the staff member responsible for exclusions and readmissions should be kept informed of current regulations. The nurse also helps teachers develop skills in observing symptoms which might indicate the onset of an acute communicable disease.

Working With Parents or in the Home, the Nurse

- Acts as a guest in the home.
- Tries to increase parents' understanding of the needs for communicable disease control.
- Encourages parents to keep children at home and under observation when acute symptoms appear. If a communicable disease develops, children should stay at home until recovery is complete.
- Gives information to increase skills in avoiding exposure to communicable disease.
- Encourages vaccination and immunization for children.
- Demonstrates nursing care, isolation techniques, and effective handwashing techniques.
- Discusses regulations governing contacts, food handling, or other possible dangers of spreading disease.
- Provides appropriately written instructions and/or leaflets, and discusses control measures for particular diseases.
- Outlines plans for the child's return to school.

Working With the Community, the Nurse

- Encourages programs that provide for immunization of all children in the community through either private physicians or public clinics.

The rules and regulations concerning communicable disease control, established by the Texas Department of Health, are provided in Section BB.

COMMUNICABLE DISEASE CHART

DISEASE	INCUBATION PERIOD	EARLY SIGNS OF ILLNESS	ISOLATION	NOTES
Athlete's Foot	Unknown	Blisters and cracking of the skin of the feet, usually between the toes.	Not excluded from school. Suspected cases should be excluded from gymnasiums, swimming pools, and activities likely to lead to exposure of others.	Teach importance of hygienic care. Refer to private physician or Health Department.
Chickenpox	2 to 3 weeks	Slight fever, fine blisters appear first on scalp, then on face and body. Successive crops of blisters remain 3-4 days, leaving scars.	Six days after last crop of blisters appear.	No vaccine available. Consult your physician.
Common Cold	12 to 72 hrs. Usually 24 hrs.	Runny nose, watery eyes, chilliness and malaise. Usually no fever, unless complications have developed.	Until clinical recovery.	
Diphtheria	2-5 days, occasionally longer	Sore throat, fever, the symptoms rapidly become more severe.	Until two cultures from both nose and throat, taken after cessation of antimicrobial therapy and not less than 24 hours apart, fail to yield diphtheria bacilli.	Vaccine available. Consult your physician or Health Department.
Epidemic Meningitis	Varies from 2-10 days. Commonly 3-4 days	Sudden onset of headache, fever, nausea and often vomiting, stiff neck. Frequently a fine spotted rash appears.	Exclude from school until released by private physician or Health Department.	Consult your physician.
Head Lice (Pediculosis)	Eggs hatch in a week; reach sexual maturity in about 2 wks.	Excessive scratching of head. White egg (nit) on hair that will not flick off.	Exclude until under treatment.	Refer to private physician or Health Department.
Viral Hepatitis A. Infectious	From 15 to 50 days. Usually 25 days.	Nausea, vomiting, extreme fatigue, often pain in upper abdomen followed by jaundice. Mild cases occur without jaundice in children.	Exclude from school until released by private physician or Health Department.	Supervised handwashing after using the toilet and before meals will help control spread. Personal hygiene is emphasized. See your physician.
B. Serum	45-160 days Average 60-90 days.	Masked onset, loss of appetite, vague abdominal discomfort, nausea, vomiting, often progressing to jaundice.	Exclude from school until released from medical supervision.	
Impetigo	Variable	Small blisters on the skin which later become crusted and contain pus.	Permit school attendance if under adequate treatment.	Refer to private physician or Health Department.
Influenza	24-72 hrs.	Rapid onset with fever, chills, headache, lack of energy, muscle aching, sore throat, cough.	Until clinical recovery.	
Measles— Rubeola	7 to 14 days	Runny nose, watery eyes, fever, cough. Blotchy rash appears 4th day.	During catarrhal state and for 7 days after appearance of rash.	Vaccine available. Consult your physician or Health Department.
German Measles— Rubella	14 to 21 days	Slight head cold. Swollen, tender glands at back of neck. Changeable rash.	Until clinical recovery.	Vaccine available. Consult your physician or Health Department.
Mumps	12 to 26 days	Pain in cheeks, increased by chewing. Swelling over the jaw and in front of ear.	Until swelling disappears.	Vaccine available. See your physician.
Pink Eye— Conjunctivitis	Usually 24 to 72 hrs.	Red eyes, discharge from eyes, crusted lids.	Exclude until released by private physician.	Consult your physician.
Poliomyelitis	Commonly 7-12 days with a range from 3-21 days	Fever, headache, malaise, gastrointestinal disturbance, stiffness of the neck and back. Often followed by paralysis.	Exclude from school until released by physician or Health Department.	Can be prevented by vaccination. See your physician or Health Department.

Communicable Disease Chart

Section E-4.1

Rickettsial Disease A. Rocky Mtn. Spotted Fever	3 to 10 days	Sudden onset, moderate to high fever, ordinarily persisting 2-3 wks., headaches, chills, redness of eyes. Raised rash on extremities progressing to palms and soles.	Not necessary.	Transmitted by tick bites. Not directly communicable from man to man.
B. Typhus	1 to 2 wks.	Headaches, chills, lack of energy, fever, aches, raised rash appearing on the 5th or 8th day.	Not necessary.	Transmitted by flea bites. Not directly communicable from man to man.
Ringworm of the Body	4-10 days	Flat, spreading, scaly, ring-shaped spots. The margins are usually reddish and elevated.	Permit school attendance if under adequate treatment and sores are covered.	Refer to private physician or Health Department.
Ringworm of the Scalp	10-14 days	Flat spreading, ring-shaped bald spots on hairy parts of head.	Exclude unless under adequate treatment. Consult Health Department for current regulations.	Refer to private physician or Health Department.
Salmonellosis	6-72 hrs.	Sudden onset, abdominal pain, diarrhea, nausea, vomiting and fever.	Exclude until released by physician.	
Scabies	Several days or weeks	Small raised reddened areas or blisters with connecting grayish-white lines. Marked itching. Most commonly found in folds of the skin.	Exclude until under adequate treatment and no open lesions can be observed.	Refer to private physician or Health Department.
Shigellosis	1-7 days	Diarrhea, cramps, fever, vomiting.	Exclude from school until released by physician.	
Streptococcal Infections (Including Scarlet Fever)	1-3 days	Fever, sore throat. Fine red rash over body for Scarlet Fever.	For at least 7 days from onset if untreated. With adequate medical treatment, 48 hrs.	No vaccine available. Consult your physician.
Tetanus	4 days to 3 weeks	Painful muscular contractions—primarily of the masseter (jaw) and neck muscles.	Not necessary.	Vaccine available. Consult physician or Health Department.
Tuberculosis	4-12 weeks from infection to demonstrable pulmonary lesion	Listlessness, loss of appetite, weight loss, low grade fever, positive tuberculin skin test.	Case: If proved to be noninfectious and physical condition permits, may attend school. Contacts: May attend school but should have TB skin tests. If positive, child should be referred to his family physician for further study.	If reactor prevalence is 1% or greater, recommend TB skin tests of 1st and 7th grade school children to identify Tuberculin reactors for referral to physician for further study.
Venereal Disease A. Gonorrhea	3-5 days	Male—Purulent urethral discharge; burning on urination; inflammation & swelling of genital region. Female—Possibly no symptoms; vaginal discharge, pain in abdomen (when salpingitis occurs).	Not necessary.	Refer to private physician or Health Department. National Venereal Disease Hotline—1-800-227-8922 — Toll Free
B. Syphilis	21 days	1st sign—genital sore (5 week duration); 2nd sign—generalized rash, mucous patches, sore throat, headache, fever alopecia, etc. (7 weeks duration).	Not necessary.	Refer to private physician or Health Department. National Venereal Disease Hotline—1-800-227-8922 — Toll Free
Whooping Cough Pertussis	7 to 10 days	Tight dry cough which becomes more severe. Cough, whoop, and vomit.	For 21 days after appearance of typical "whoop."	Vaccine available. Consult your physician or Health Department.

Immunizations

Section E-5.0

Immunization requirements are established by the Texas Department of Health. School districts are required by the State Board of Education to have written policies on immunization compliance standards for students. School nurses are usually the personnel assigned by school administrators to assure the students are in compliance.

Schools are required to keep careful immunization records on each student. Time spent on record keeping activities and parent/student contact regarding immunizations should be included on a suitable reporting form (see Section CC). High immunization protection levels and other appropriate communicable disease control measures can make a significant impact on a district's Average Daily Attendance (ADA).

Many school districts have computerized student immunization records and medical problem notations. Nurse extenders may assist the school nurse in keeping computer information up-to-date. The regional education service centers may help in the establishment of programs. Sample computer keypunch forms follow (see Sections E-5.1 and 5.2).

Section 2.09 of the Texas Education Code requires all students to be immunized against diphtheria, rubeola (measles), rubella, tetanus, and poliomyelitis. The Texas Department of Health is required to provide these immunizations in areas where local service is unavailable. The law further states that the Department of Health may modify or delete any of the required immunizations, or require immunization against additional diseases (i.e., mumps). Rules and regulations pertaining to provisional admission are also promulgated by the Health Department. Immunization laws are reprinted in Section BB of this handbook. A sample immunization card is included in Section E-5.5.

A "Suggested Schedule for Routine Immunizations" is provided in Section E-5.3. This schedule is compatible with recommendations from the American Academy of Pediatrics (AAP) and the Public Health Service Advisory Committee on Immunization Practices (ACIP). Such recommendations often call for a larger number of doses for immunization against diphtheria, tetanus, pertussis, and poliomyelitis.

Districts are required to submit a report of immunization status for students usually in December of each year. This report is developed jointly by the Texas Education Agency and the Texas Department of Health. The reporting forms are distributed by Texas Education Agency and are returned to the Agency (see form, Section E-5.4). Texas Department of Health compiles the reported data and publishes *Texas Public School Immunization Report*.

NOTE: Representatives of the Texas Department of Health and local health departments will, upon request, assist school administrators in meeting requirements of the law.

Section E-5.1

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Sample 2: Keypunch Form

Section E-5.2

RECORD OF IMMUNIZATIONS

Name _____		STUDENT IDENTIFICATION										Check Digit
		LOCATION		STUDENT NUMBER								
Grade _____	Sex _____	Advisor _____	0	0	0	0	0	0	0	0	0	0
Birthdate _____			1	1	1	1	1	1	1	1	1	1
Parent/Guardian _____			2	2	2	2	2	2	2	2	2	2
Address _____			3	3	3	3	3	3	3	3	3	3
Zip Code _____	Telephone _____		4	4	4	4	4	4	4	4	4	4
			5	5	5	5	5	5	5	5	5	5
			6	6	6	6	6	6	6	6	6	6
			7	7	7	7	7	7	7	7	7	7
			8	8	8	8	8	8	8	8	8	8
			9	9	9	9	9	9	9	9	9	9

DPT				DT				POLIO			
First	Second	Third	Booster	First	Second	Third	Booster	First	Second	Third	Booster
Mo	Year	Mo	Year	Mo	Year	Mo	Year	Mo	Year	Mo	Year
1	0	1	0	1	0	1	0	1	0	1	0
2	1	2	1	2	1	2	1	2	1	2	1
3	2	3	2	3	2	3	2	3	2	3	2
4	3	4	3	4	3	4	3	4	3	4	3
5	4	5	4	5	4	5	4	5	4	5	4
6	5	6	5	6	5	6	5	6	5	6	5
7	6	7	6	7	6	7	6	7	6	7	6
8	7	8	7	8	7	8	7	8	7	8	7
9	8	9	8	9	8	9	8	9	8	9	8
10	9	10	9	10	9	10	9	10	9	10	9
Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

Measles	Rubella	Mumps			
Mo	Year	Mo	Year	Mo	Year
1	0	1	0	1	0
2	1	2	1	2	1
3	2	3	2	3	2
4	3	4	3	4	3
5	4	5	4	5	4
6	5	6	5	6	5
7	6	7	6	7	6
8	7	8	7	8	7
9	8	9	8	9	8
10	9	10	9	10	9
Re-action	Re-action	Re-action			
YES	YES	YES			
NO	NO	NO			

LONG TERM MEDICATION	
YES	NO

TB SKIN TEST	
1st Grade	POS NEG
7th Grade	POS NEG

EXCLUSION	
Medical	Religious
Other	None

STUDENT MEDICAL INFORMATION		
	Yes	No
CONVULSIVE DISORDER		
VISUAL IMPAIRMENT		
SPEECH IMPAIRMENT		
HEARING IMPAIRMENT		
DIABETIC DISORDER		
ORTHOPEDIC DISORDER		
RHEUMATIC FEVER		
RESPIRATORY DISORDER		
OTHER IMP/DISORDER		

Suggested Schedule for Routine Immunizations Texas Department of Health

Section E-5.3

SUGGESTED SCHEDULE FOR ROUTINE IMMUNIZATIONS IN PUBLIC HEALTH CLINICS IN TEXAS

The following schedule and recommendations are compatible with those of the American Academy of Pediatrics (AAP) and the Public Health Service Advisory Committee on Immunization Practices (ACIP).

AGE	IMMUNIZING AGENTS	AGE	IMMUNIZING AGENTS
2 months	DTP, Trivalent OPV	12-18 month	DTP, Trivalent OPV
4 months	DTP, Trivalent OPV	4-6 years	DTP, Trivalent OPV
6 months	DTP, Trivalent OPV*	14-16 years	Td Adult
15 months	Measles, Mumps, Rubella	THEREAFTER	Td Adult every 10 years

*6-month OPV optional — see below.

BASIC IMMUNIZATIONS

Children and other young persons not previously immunized may be given basic immunizations at any age.

POLIO

Trivalent OPV is recommended:

Series begun under 1 year of age—two doses administered two months apart, plus a booster 6 to 12 months later and a final booster at 4-6 years of age. CAUTION: In those population groups where there is a significant risk of exposure to wild polio strains within those groups, an additional dose of OPV at 6 months of age should be considered.

Series begun at ages 1 through 17 years—two doses administered two months apart, plus a booster 6 to 12 months later. (And another at ages 4-6 years, for children completing series before the fourth birthday.)

Age 18 and above—routine immunization not recommended, except on an individualized basis due to increased risk.

Although other booster doses are not routinely recommended, an additional dose of trivalent OPV is indicated in the presence of poliomyelitis in the community, or before travel to endemic or epidemic areas. Salk polio vaccine is recommended for children (and their siblings) with immunodeficiencies, and for primary immunization of adults; see reverse for dosage.

DTP/Td ADULT

DTP may be used for either basic or booster immunizations through the age of six years. Individuals seven years of age and older should receive combined tetanus and diphtheria toxoids, Td (adult) in a series of two doses spaced 4 to 8 weeks apart, followed by a third, reinforcing dose 6 to 12 months later. A DTP booster is recommended at age 4-6 years; and Td boosters are recommended at age 14-16 years and every ten years thereafter.

MEASLES, MUMPS, AND RUBELLA VACCINES

Single-antigen measles vaccine should be given to infants as young as six months of age if there is likely exposure to natural measles prior to the recommended dose at age 15 months. Unless physician-diagnosed measles has occurred, or there is laboratory evidence of measles immunity, the following persons should be revaccinated with measles vaccine: (1) those vaccinated with live measles vaccine before 12 months of age; (2) those vaccinated at any age with inactivated vaccine (available from 1963 through 1967); (3) persons who are unaware of their age at vaccination; (4) those vaccinated prior to 1968 with a vaccine of unknown type; (5) persons immunized with live, further attenuated measles vaccine (e.g. Schwarz®, Moraten®, or unknown strains), along with immune serum globulin, regardless of age at time of vaccination; and, (6) those who received live measles vaccine within 3 months of inactivated measles vaccine.

Measles, mumps, and rubella vaccines may be administered to post-pubertal females only after interviews with qualified health clinic personnel have provided information that they are not pregnant and have been advised of the theoretical danger of concurrent vaccination and early pregnancy.

PREGNANCY

It is recommended that susceptible pregnant women be immunized against tetanus and diphtheria. Td (adult) is the recommended antigen and should be started as early as possible with two doses given 4 to 6 weeks apart. If the second dose is given during the first or second trimester, a third dose should be given about one month before term. Individuals previously fully immunized, but whose last dose was received 10 or more years ago, should be given a single dose of Td (adult) about one month prior to term.

LIVE VIRUS VACCINES WILL NOT BE ADMINISTERED TO PREGNANT WOMEN, OR WOMEN UNWILLING OR UNABLE TO PREVENT PREGNANCY DURING THE THREE MONTHS FOLLOWING IMMUNIZATION WITH LIVE VIRUS VACCINES. Non-immunized pregnant women who need immunization because of exposure to measles, rubella or poliomyelitis may, on the prescription of a physician, be immunized temporarily with immune serum globulin.

INTERRUPTION OF SCHEDULE

Delayed intervals between doses do not necessitate starting the series of inoculations over again.

SIMULTANEOUS ADMINISTRATION OF VACCINES

OPV, DTP/Td, and M-M-R vaccines may be administered simultaneously when there is doubt that the child will return for further doses.

PERSONAL IMMUNIZATION RECORDS

The Texas Department of Health will supply two forms that can be used to record immunization data: C-11 (Immunization Record, For Clinic Use, 3" x 5"); and C-102 (Personal Immunization Record, billfold size).

GENERAL

An interval of at least one month should be allowed between the administration of live virus vaccines, unless they are given simultaneously as mentioned above. When for any reason a tuberculin skin test is not administered simultaneously with live virus vaccines (including measles), the skin test should be administered and read either before, or at least thirty days after, the administration of live virus vaccines.

June 1982

(Back of Schedule)

IMMUNIZATION REFERENCE SCHEDULE

VACCINE	AGE		DOSAGE AND METHOD	SCHEDULE		REMARKS
	Minimum	Maximum		Vaccine	Boosters	
DTP	2 months	7th birthday	0.5cc Intramuscular	3 doses (1 or 2 month intervals)	6-12 mos. later Then after 4th birthday	See note 1
Td	7 years	NONE	0.5cc Intramuscular	2 doses (1 or 2 month intervals)	6-12 mos. later Then every 10 years	See note 1
Polio, oral	6 weeks	18th birthday	2 drops on sugar cube or on tongue	2 doses (optional 3rd dose at age 6 months)	6-12 mos. later and after 4th birthday	Live virus See notes 1, 2, 5
Measles	6 months	NONE	0.5cc Subcutaneous	1 dose	See note 3	Live virus See notes 3, 4, 5, 6
Mumps	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 4, 5, 6
Rubella	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 4, 5, 6
Measles-Rubella	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 3, 4, 5
Measles-Mumps-Rubella	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 3, 4, 5, 6
Polio, injectable	6 weeks	NONE	1.0cc Subcutaneous	3 doses at 1-2 mo. intervals, plus dose 6-12 mos. later	Every 5 years	See notes 1, 7

NOTES:

1. Delayed intervals between doses do not necessitate starting the series of inoculations over again.
2. Polio should be started at 6-8 weeks of age: 2 doses 2 months apart, optional 3rd dose at age 6 months, and boosters 6-12 months later and after 4th birthday. Polio for persons 1 thru 17 years: 2 doses 2 months apart and booster 6-12 months later, and after 4th birthday if applicable.
3. A physician-verified history or laboratory evidence of measles illness may be substituted for measles vaccine. Infants as young as six months of age should receive single-antigen measles vaccine if there is likely exposure to natural measles prior to the recommended 15-month dose. A measles booster is required for persons without physician-verified history or laboratory evidence of measles illness who received measles vaccine under the age of 12 months, as well as for persons previously immunized with inactivated (killed) measles vaccine.
4. Measles, mumps and rubella vaccines may be administered during the same clinic visit, using either combined M-R or M-M-R vaccines at one injection site, or monovalent vaccines at separate injection sites.
Measles, mumps, and rubella vaccines may be administered to post-pubertal females only after interviews with qualified health clinic personnel have provided information that they are not pregnant and have been advised of the theoretical danger of concurrent vaccination and early pregnancy.
5. An interval of at least one month should be allowed between the administration of live virus vaccines, unless they are given simultaneously as mentioned in number 4, above.
6. If a child from 12 to 15 months of age is seen in an immunization clinic, and there is doubt that the child will return for the scheduled dose of M-M-R vaccine at age 15 months, then M-M-R vaccine should be administered to the child while at the clinic. A later booster is not required.
If a clinic is temporarily out of stock of the appropriate single-antigen products, and if two of the three antigens in M-M-R are needed by a patient, it may be appropriate to administer M-M-R, unless there are contraindications to the individual antigenic components.
Histories of measles and mumps illnesses are not acceptable unless validated in writing by a physician, or confirmed by laboratory tests.
7. Injectable polio vaccine (IPV, Salk) is to be used only when oral polio vaccine is medically contraindicated. IPV can be administered during the same clinic visit as DTP/Td, provided separate injection sites are used. The dosage and method of administration above are for IPV vaccine manufactured by Connaught Laboratories, Ltd. Consult package insert for dosage and method of administration if another brand of IPV is being used.

Annual Report of Immunization Status Form

Section E-5.4

TEXAS EDUCATION AGENCY
Data Services Division

District Name _____

County-District No. _____

Annual Report of Immunization Status

Authority for Data Collection: Texas Education Code, Section 2.09 and 2.09a.**Planned Use of the Data:** To measure compliance with Section 2.09 and 2.09a, Texas Education Code and determine need for further immunizations.**Instructions:** Complete items below and on reverse side as applicable. Use the membership on the last day of the second six weeks reporting period. Contact Jerry Davis at (512) 475-6234 if help is needed in completing this form.

A. What was the total membership of the school district? Number _____		How many of the total membership have received 3 or more doses of DTP or Td, including at least one dose since the fourth birthday and within the last ten years? A dose received in the calendar month prior to, or of, the fourth birthday may be counted as a dose since the fourth birthday. Number _____ If this number is less than total membership, also complete item A on reverse.
B. How many of the total membership are under age 18? Number _____		How many under age 18 have received 3 or more doses of oral polio vaccine, including at least one dose since the fourth birthday? A dose received in the calendar month prior to, or of, the fourth birthday may be counted as a dose since the fourth birthday. Number _____ If this number is less than membership under age 18, also complete item B on reverse.
C. Same as total membership.		How many of the total membership have received at least one dose of measles vaccine on or after the first birthday, or during the calendar month of the first birthday and since January 1, 1968; or have provided a physician-validated history of measles illness? Number _____ If this number is less than total membership, also complete item C on reverse.
D. How many of the total membership are under age 12? Number _____		How many under age 12 have received at least one dose of rubella vaccine? Number _____ If this number is less than membership under age 12, also complete item D on reverse.
E. How many of the total membership are under age 11 as of September 1, 1982? Number _____		How many under age 11 have received at least one dose of mumps vaccine, or have a physician verified history of mumps illness? Number _____ If this number is less than membership under age 11, also complete item E on reverse.
Typed Name of Authorized School Official _____	Telephone _____	Date _____

Please return one copy, by December 15, 1982, to:
Texas Education Agency
Data Collection, Data Services Division
201 East 11th Street
Austin, Texas 78701

Signature of Authorized School Official _____

RES-016R83

(Back of Form)

STUDENTS NOT COMPLETELY IMMUNIZED

- A. DIPHTHERIA/TETANUS: Number of students with
- | | |
|-------------------------------------|-------|
| Incomplete series (but on schedule) | _____ |
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | |

Remarks:

- B. POLIO: Number of students with
- | | |
|-------------------------------------|-------|
| Incomplete series (but on schedule) | _____ |
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | |

Remarks:

- C. MEASLES: Number of students with
- | | |
|------------------------|-------|
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | |

Remarks:

- D. RUBELLA: Number of students with
- | | |
|------------------------|-------|
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | |

Remarks:

- E. MUMPS: Number of students with
- | | |
|------------------------|-------|
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | |

Remarks:

*PAST DUE FOR REQUIRED IMMUNIZATION(S)

Personal Immunization Record

Section E-5.5

VACCINES	DATE GIVEN	VALIDATION DOCTOR OR CLINIC
DTP or Td	1	
	2	
	3	
	4	
	5	
	6	
	7	
Polio ☐ Oral ☐ IPV	1	
	2	
	3	
	4	
	5	
Measles		
Mumps		
Rubella		
Other		
TO TEST	DATE	RESULT

PHYSICIAN'S VERIFICATION OF MEASLES/MUMPS ILLNESS
This is to verify that the person for whom this card was issued had:

- ☐ measles illness on or about _____ month and year
- ☐ mumps illness on or about _____ month and year
- and does not need the vaccine/s.

Date

Physician's Signature

THIS RECORD IS VALUABLE!

AN IMMUNIZATION RECORD IS REQUIRED WHEN ENTERING A
CHILD CARE FACILITY OR SCHOOL IN TEXAS. DO NOT LOSE OR
GIVE THIS RECORD AWAY.

SUGGESTED IMMUNIZATION SCHEDULE

AGE	VACCINES
2 months	DTP and Polio
4 months	DTP and Polio
6 months	DTP and Polio*
15 months	Measles, Mumps & Rubella
12-18 months	DTP and Polio
4-6 years	DTP and Polio
14-16 years	Td
Thereafter	Td every 10 years
*6 month polio dose optional	

YOUR PHYSICIAN MAY WISH TO CHANGE
THE ABOVE SCHEDULE

TEXAS DEPARTMENT OF HEALTH
Bureau of Communicable Disease Services

PERSONAL IMMUNIZATION RECORD

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

CLINIC APPOINTMENTS

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

TAKE THIS RECORD EACH TIME YOU VISIT YOUR PHYSICIAN OR
CLINIC SO THAT DATES OF IMMUNIZATIONS CAN BE RECORDED



(1982)

Form No. C-102

Reportable Diseases of Texas

Section E-6.0

Texas law requires that physicians report cases of communicable diseases to the local health departments, city or county health officers, or public health regional offices which will then transmit the information to the Texas Department of Health.

Any unusual or group expression of illness which may be of public health concern should also be reported to local health authorities or the state epidemiologist as quickly as possible (512/458-7207, or Tex-An: 512/824-9207).

Epidemiologic investigative consultation and assistance are available from the Texas Department of Health upon request.

Tuberculosis cases are reported individually on Tuberculosis Report Form, TB-15. Include name, address, birthdate, sex, race, and social security number, with pertinent information on the status of the disease.

Syphilis, Gonorrhea, Chancroid, Granuloma Inguinale, and Lymphogranuloma Venereum cases are reported individually on VD Report Card J-27, "Confidential Report of Venereal Disease," with pertinent information on the status of the disease being reported. Personal data required include name, address, sex, age, race, marital status, date of examination, treatment, and other specific information.

Reportable Diseases of Texas (List)

Section E-6.1

REPORTABLE DISEASES OF TEXAS

By virtue of the authority vested in the Board of Health by Articles 4418a and 4419, of the Texas Civil Statutes, certain rules and regulations have been established to control communicable diseases. The Board of Health has established methods of procedure in pursuance of Rules 1-33 of Article 4477 of the Texas Civil Statutes and has designated the following as reportable diseases in Texas:

Diseases to be Reported Immediately by
Telephone to the Texas Department of Health

Botulism	Plague	Smallpox
Cholera	Poliomyelitis, paralytic	Yellow fever
Diphtheria		

Diseases Reportable by Name, Address, Age, Sex, and Race/Ethnicity

Amebiasis	Leptospirosis	Rubella
Anthrax	Malaria	Rubella congenital syndrome
Aseptic meningitis	Measles	Salmonellosis
Botulism	Meningococcal infections	Shigellosis
Brucellosis	Mumps	Smallpox
Cholera	Pertussis	Tetanus
Diphtheria	Plague	Trichinosis
Encephalitis (specify etiology)	Poliomyelitis, paralytic	Tularemia
Hansen's disease (leprosy)	Psittacosis	Typhoid fever
Hepatitis, viral	Q fever	Typhus fever, endemic (murine)
Type A	Rabies in man	epidemic
Type B	Relapsing fever	Yellow fever
unspecified	Rheumatic fever, acute	
	Rocky Mountain spotted fever	

Diseases Reportable by Numerical Totals

Chickenpox	Streptococcal sore throat
Influenza and flu-like illness	(including scarlet fever)

Texas state law requires that physicians report cases of communicable diseases to the local health departments, city or county health officers, or Public Health Regional offices, who in turn transmit the reports to the Texas Department of Health.

In addition to the requirements of individual case reports, any unusual or group expression of illness which may be of public health concern should be reported to the local health authorities or the State Epidemiologist by the most expeditious means (AC 512) 458-7676 or STS 824-9676.

Epidemiologic investigative consultation and assistance are available from the Texas Department of Health upon request.

According to Rule b, Section .012 of the Rules and Regulations for the Control of Communicable Diseases, local school authorities shall report to the local health authority, those children attending school who are suspected of having a communicable disease or a disease requiring exclusion from school. Procedures for determining which children should be so suspected and reported, and for their exclusion from school pending appropriate medical diagnosis or recovery, shall be defined by the local health authority.

Bureau of Communicable Disease Services
Texas Department of Health

July 1980

Child Abuse

Section E-7.0

Child abuse is an extremely serious problem in our society. In 1981 there were 47,340 cases of suspected abuse and neglect reported to the Texas Department of Human Resources. During the year 1981, 110 children were known to have died from child abuse in the state. Increased public awareness has led to more cases being reported and more child abuse cases discovered. Health care providers should be acutely aware of the problem of child abuse.

The etiology of child abuse may have causal factors. The interrelationships between the child, parent, family, community, and society must be considered. Listed below are factors commonly associated with child abuse.

Factors Contributing to Child Abuse

By the Child:

- Prematurity, inadequate bonding to mother.
- Developmental or intellectual delay.
- Chronic or acute illness.
- Psychological problems.
- Product or unwanted pregnancy.
- Cause of financial burden.
- Behavior which provokes violence; actions to attract attention.

By the Parents:

- Use of violence to resolve conflicts.
- Psychological problems.
- Distorted expectancy of child; lack of knowledge of growth and development.
- Social isolation or rejection.
- Frustrated dependency needs.
- Power dominance of one parent over the other.
- Single parent home.
- High degree of stress.
- Lack of saleable job skills.

By Family:

- Unemployment.
- Inadequate housing.
- Loss of family member.
- Frequent relocation of residence.
- Social isolation or rejection by community.
- Lack of extended family support.

By Community:

- Environmental stress.
- Overcrowded neighborhoods.
- Isolation—non-supportive, geographic mobility.
- Lack of employment opportunities.
- Rejection of weak or dependent families.

By Society:

- Competition valued rather than cooperation.
- Physical force accepted as method of resolving conflict.
- Societal acceptance of corporal punishment.
- Violence depicted through media.

Usually child abuse is the result of a family crisis or series of crises with some triggering, stressful event. Schools may foster communication, coordination, and cooperation in the community to assist parents in learning how to deal with or resolve stress. The resolution almost always involves counseling for the entire family, not just the abusive person. Treatment generally requires a team effort, including numerous professionals: nurses, physicians, psychologists, social workers, educators, counselors, attorneys, and child care workers.

The task of determining whether a child has been physically, sexually, or emotionally abused is difficult. Even more of a dilemma occurs in trying to make a judgment regarding maltreatment or neglect. Cultural norms must be considered, though not used as an excuse or justification for maltreatment. Primary consideration must be for the health, welfare, and safety of the child.

The importance of documentation of suspected child abuse cannot be overemphasized. Along with the date, time, and name of the person notifying the nurse, both physical and emotional findings must be explicit and well-detailed. Do not rely on memory. Rather, keep a personal memorandum concerning each finding.

Notation Should Be Made As To

- When, where, and how did the "accident" occur?
- In what state of healing is the bruise, laceration, or burn?
- Size and shape of bruise, laceration, or burn.
- Does the mark(s) appear new or several days/months old?
- Are there other injuries in various stages of healing?
- What part of the body is affected?
- Does the child appear fearful or protective of the parent?
- Were other people present when the incident occurred?
- Are there other siblings in the home? Do they have "hurts" like these?

Examples of Observable Abuse

- Extensive bruises. Bruises in various stages of healing. Patterns of bruises caused by a particular instrument (belt buckle, wire coat hangers).

- Burn patterns consistent with forced immersion in a hot liquid (distinct boundary line where the burn stops). Burn patterns consistent with a spattering by hot liquid. Patterns caused by a particular kind of implement (electric iron), instrument, or circular cigarette burns.
- Lacerations, welts, abrasions, and/or contusions.
- Injuries inconsistent with information offered.
- Suspicious fractures in children less than three years old; sprains or dislocation.
- Multiple, frequent injuries.
- Skull fractures, subdural hemorrhage or hematoma.
- Human bites.
- Loosened or missing teeth accompanied by lacerated lips.
- Rope marks or burns.
- Poisoning.
- Child is described as "different" in physical and emotional makeup.
- Sexual abuse in any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy, or unnatural or perverted sexual practices.

Examples of Observable Neglect

- Malnourished; ill-clad by community norms; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care.
- Unattended; without adequate supervision; abandonment.
- Ill and lacking essential medical attention.
- Destructive and aggressive behavior exhibited by child.
- Irregular school attendance; truancy.
- Exploited; overworked.
- Emotionally disturbed because of continuous friction in the home; marital discord; mentally ill parents.
- Cruel treatment.
- Depression; suicide gestures; extreme fatigue; anorexia; insomnia; withdrawal; passiveness.
- Child denied experiences of being loved, wanted, secure, or worthy.
- Exposure to unwholesome circumstances.

Common Findings in Abusive Parents

- Parent(s) appears to be misusing drugs or alcohol.
- Contradictory stories regarding child's injury.
- Discourages child forming social contact.
- Evasive answers to questions.
- No voluntary information given regarding any injuries.
- Unrealistic expectations for the child.
- Anger directed at child for being injured.

- Inappropriate response to the child's crying or pain.
- Little touching of the child.
- Little direct eye contact between parent and child.
- Little tenderness shown toward the child.
- Lack of concern regarding child's injury.
- Little or no interest shown for child's treatment.
- Poor relationships with own parents.
- Reared in homes where excessive punishment was the norm.
- Tend to be antagonistic, suspicious, and fearful of others.
- Neglectful of own physical health.
- Personal or marital problems.
- Isolated and transient; seems to have no one to call upon when stresses of parenthood are overwhelming.
- Grew up in unloving atmosphere under harsh discipline, and feel the right to impose same conditions on a child.

Reporting Procedures

Any person who believes that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect must report these suspicions to the Texas Department of Human Resources, and to a law enforcement agency.

An oral report must be made immediately to the nearest office of Child Protective Services, Texas Department of Human Resources, or to the 24-hour Child Abuse Hotline (1-800-252-5400), and to a local law enforcement agency. A written report must be made within five days.

School personnel suspecting child abuse or neglect may use the following steps when reporting such cases:

- The report may first be made to the building principal who may handle any cases in the school.
- The principal may ascertain the facts in the case and may call in one or more of the following: school nurse, teacher, visiting teacher, counselor, or others.
- If the principal suspects child abuse or neglect, the Child Protective Services, Texas Department of Human Resources, and a law enforcement agency should be called immediately to apprise them of the case. An oral report is required by law and may be made also through a Child Abuse Hotline (1-800-252-5400).
- If flagrant abuse is observed, photographs should be made. This, however, shall be the responsibility of the Child Protective Services. Taking photographs is a phase of investigation, and investigation is not the responsibility of the school.
- Nothing in this handbook is intended to prevent the individual nurse, teacher, or other school-related persons from reporting directly to the Child Protective Services or to a local law enforcement agency. The law states that it is a misdemeanor not to report suspected child abuse under penalty of a fine or jail sentence, or both. Being a nurse or a teacher and at school does not relieve anyone of this duty.
- School personnel who may be called as witnesses in court on child abuse cases should be permitted to testify without loss of school salary.

A suggested reporting form is provided in Section E-7.1. School districts may wish to adapt the form to local needs. However, if major changes are made, the school attorney should be consulted.

Report of Child Abuse or Neglect

Section E-7.1

IT'S THE LAW: Any person who believes that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or that a child has died of abuse or neglect, must report his or her suspicions to the Texas Department of Human Resources and to a law enforcement agency.

An oral report must be made immediately to the nearest office of Child Protective Services, Texas Department of Human Resources, or to the 24-hour Child Abuse Hotline (1-800-252-5400), and to a local law enforcement agency. A written report must be made within five days.

IMMUNITY: A person who, without malice, makes a report or suspected child abuse or neglect is immune from civil or criminal liability.

CONFIDENTIALITY: Reports of child abuse or neglect are confidential. Information in the reports, including the name of the person who makes the report, may be used only for purposes consistent with the investigation of abuse or neglect.

FAILURE to report suspected physical or mental abuse or neglect of a child in Texas is a crime punishable by fine, imprisonment, or both.

(The form below is furnished to help Texans comply with the law.)

Detach, seal, and mail

REPORT OF CHILD ABUSE OR NEGLECT

Name of Child	Date of Birth or Age of Child	Today's Date
Child's Home Address (Street, City, State, ZIP)		
NAMES OF PARENTS OR PERSONS RESPONSIBLE FOR CHILD		RELATIONSHIP TO CHILD

Does the child have any brothers or sisters? ☐ Yes ☐ No ☐ Don't Know

When and where can the child be seen? (give dates and places) _____

Type of Child Abuse or Neglect	
☐ Burning	☐ Beating
☐ Fracture	☐ Sexual Abuse
☐ Abandonment	☐ Malnutrition
☐ Internal Injuries	☐ Physical Neglect
☐ Medical Neglect	☐ Lack of Supervision
☐ Other (specify): _____	

Briefly describe the situation and/or condition of the child: _____

Has this report already been called in? ☐ Yes, to local Child Protective Services ☐ Yes, to Child Abuse Hotline ☐ No

If yes, date: _____ To whom? _____

PERSON MAKING THIS REPORT (Anonymous reports are accepted, but DHR staff will be able to do a better investigation if they can contact you.)

Name	Place of Employment	
Work Address (Street, City, State, ZIP)	Work Telephone No.	
OR, I prefer to be contacted at home: ☐	Home Address (Street, City, State, ZIP)	Home Telephone No.

Suicide

Section E-8.0

The incidence of suicide in teens, 15-19 years old, has tripled in the past ten years. The Bureau of Vital Statistics places suicide as the third most frequent cause of death in teenagers in Texas during 1982. The rise in suicides and attempted suicides among youth is attributed to an increase in depressive illness. One suicide attempt is often followed by another, with each succeeding attempt more likely to be successful. Girls account for more suicide attempts, but boys' attempts are more often successful. Most suicides occur at home and result from drug overdose. Analgesics, sedatives, and tranquilizers are commonly used drugs, taken impulsively as a suicide gesture.

The attempted or successful suicide may represent self-destructive impulses, aggression toward parents, or an attempt to control the behavior of other persons. Gestures or attempts may be used to induce guilt and remorse in other people. Quarrels with family or friends, school difficulty, pregnancy, or sexual problems may provide precipitating circumstances. Analysis of the gestures or attempted suicides may identify the particular "appeal for help" or intent, and provide a focus for subsequent help.

Students making suicide attempts are most likely to have: a family in which a relative has committed suicide, only one parent in the home, multiple social and emotional problems, recent evidence of escalation of problems, and evidence of social isolation or recent deterioration of social relationships. These same characteristics frequently occur in young people who are non-suicidal, making it difficult to anticipate suicide or suicidal attempts. Health professionals should consider the possibility of suicide when working with disturbed youths. Though most students attempting suicide do not wish to die and the attempts are frequently unsuccessful, none should be regarded lightly.

School health personnel with knowledge of a youth's suicide gesture or attempt have an obligation to discuss it with the student at once and, with or without the student's consent, to make this information known to the parents immediately.*

*American Academy of Pediatrics, *School Health: A Guide for Health Professionals* (Evanston, Illinois: The Academy, 1981).

Facts and Fables on Suicide

Section E-8.1

- FABLE:** People who talk about suicide, don't commit suicide.
- FACT:** Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.
- FABLE:** Suicide happens without warning.
- FACT:** Studies reveal the suicidal person gives many clues and warnings regarding suicidal intentions.
- FABLE:** Suicidal people are fully intent on dying.
- FACT:** Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he or she is feeling.
- FABLE:** Once a person is suicidal, he is suicidal forever.
- FACT:** Individuals who wish to kill themselves are "suicidal" only for a limited period of time.
- FABLE:** Improvement following a suicidal crisis means that the suicidal risk is over.
- FACT:** Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.
- FABLE:** Suicide strikes more often among the rich—or conversely, it occurs almost exclusively among the poor.
- FACT:** Suicide is neither a rich man's disease nor the poor man's curse. Suicide is very "democratic," and it is represented proportionately among all levels of society.

FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he or she is not necessarily mentally ill.

N. L. Farberow and E. S. Schneidman, *Some Facts About Suicide* (Washington, DC: Public Health Service, Publication No. 852, U.S. Government Printing Office, 1961).

Warning Signs of Suicide

Section E-8.2

- ☐ Verbalized suicide threats.
- ☐ Statements revealing a desire to die.
- ☐ Plans made regarding how suicide will be carried out.
- ☐ Previous suicide attempts.
- ☐ Acting out daredevil acts; truancy, or delinquent behavior.
- ☐ Hyperactive or manic behavior.
- ☐ Overeating or oversleeping.
- ☐ Sudden changes in behavior (withdrawal, apathy, moodiness).
- ☐ Observable changes in peer relationships (social withdrawal, frequent absences, sudden difficulty with academic material).
- ☐ Depression (crying, sleeplessness, loss of appetite, hopelessness).
- ☐ Impulsive reactions connected with anger or acute humiliation.
- ☐ Frequent clinic visits with somatic complaints.
- ☐ Final arrangements (such as giving away personal possessions).

What To Do:

- ☐ Discuss suicide openly and frankly.
- ☐ Show empathy, interest, and support; establish rapport.
- ☐ Bring parents into situation and advise prompt consultation with a psychiatrist or community resource.
- ☐ Get professional help; establish community liaison with psychiatrist or other mental health professional.

Section F

Student Services

Section F	Student Services
	1.0 Health Counseling
	2.0 Health Instruction
	3.0 Health Screening
	3.1 Physical Assessment
	3.2 Physical Examination
	3.21 Physical Examination Form
	4.0 Growth and Development Screening
	4.1 Height Chart—Girls
	4.2 Height Chart—Boys
	4.3 Weight Chart—Girls
	4.4 Weight Chart—Boys
	4.5 Head Circumference—Girls
	4.6 Head Circumference—Boys
	5.0 Dental Screening
	5.1 Eruption Table of Teeth
	5.2 First Permanent Molars
	6.0 Vision Screening
	6.1 Basic Visual Acuity Test and Criteria
	6.2 Sample: Vision Screening and/or Eye Examination
	6.3 Sample: Vision Screening Annual Report
	7.0 Audiometric Screening
	7.1 Relationship of Degree of Impairment to Educational Needs
	7.2 Hearing Conservation Program
	7.21 Sample: User of Audiometer Registration Form
	7.22 Sample: Audiometer/Impedance Bridge Registration Application
	8.0 Scoliosis Screening
	8.1 Drawings for Scoliosis Screening
	8.2 Scoliosis Screening Worksheet
	9.0 Hypertension Screening
	9.1 Percentiles of Blood Pressure Measurement

Health Counseling

Section F-1.0

Definition

Health counseling may be defined as that interaction among the health professional, client, and/or others for more effective management of student or staff health problems.

General Goals

- To assist in maximizing learning by meeting health needs of students.
- To involve students and other health care providers in assuming responsibility for health care, health maintenance, and reenforcing appropriate health habits.
- To provide options or assistance for informed client choices and referral.

Counseling—With Students

Goal: To Involve Students in Own Health Care

The goal is for students to develop an awareness of good health behaviors and to use these behaviors in becoming responsible for own health care.

The school nurse consults and counsels with students:

- To provide information needed to prevent health problems. This counseling and/or consultation may be done with individuals or in small groups and will cover topics such as eye and ear protection, dental flossing, etc.
- To provide an interpretation of health data to those students with existing health problems. This interpretation will include recommendations on ways to use the information in preventing further health damage, e.g., spinal curvature-exercise, obesity-diet.
- To provide the immediate assistance and information needed in the management of health problems which can be remediated, e.g., preventing the spread of infectious or contagious diseases.
- To provide the information and support needed in learning to accept limitations for which there is no remediation at the present time; and build constructively toward achieving the fullest positive potential adjustment, e.g., arthritis, amputation, Spina Bifida.
- To provide information about community health and social resources which are available to furnish needed services beyond the scope of the school, e.g., hospital emergency room, public health department, community service clubs, mental health and retardation resources, and community substance abuse programs.

Goal: To Involve Parents in the Promotion of Good Health Behavior

The goal is for parents to become aware of good health practices and behaviors which will facilitate the student's learning.

The school nurse will consult and/or counsel with the family through individual or study group sessions and:

- Provide current information on health promotion and prevention practices, e.g., growth and developmental stages, healthy snack foods, personal hygiene needs of different age groups.

- Determine student's health problem(s) and assist parents in identifying health resources through activities such as school health screening and referral, development of a list of private physicians, optometrists, or community resources.
- Explain and provide specific information about health handicaps and what will be the most beneficial and least restrictive environment for both the child and other family members, e.g., blood dyscrasias.
- Explain and reenforce the medical information received from outside sources as a part of screening follow-up.

Counseling—With Staff

Goal: To Involve the School Staff in Using Health Information To Facilitate Learning for Students With Health Problems

The goal is for the school staff to become better informed about individual student health problems and make adequate environmental adjustments.

The school nurse will consult with those school staff members working with individual students who have health problems needing specific classroom accommodations:

- To provide the most effective learning environment, e.g., seating adjustment for visual/hearing difficulties or wheelchairs, restroom assistance or flexibility.
- To assist the staff in understanding and accepting limitations of handicapped students when planning curricular activities, e.g., leaf collecting-asthmatic child, bird watching-visually handicapped, manual dexterity and physical coordination-child with muscle atrophy.

Goal: To Involve Staff in Modeling Good Personal Health Practices

The goal is for the school staff to become aware of and use good personal health practices, thus serving as a model for students.

The school nurse will consult with school staff individually or in small groups by:

- Providing current information regarding good health practices which pertain to the staff's occupation and work setting, e.g., eye strain, stress, food habits.
- Identifying good health practices which may be reenforced through staff modeling, e.g., posture and exercise.
- Preventing unnecessary health problems and promoting good health practices, e.g., use of health week activities, bulletin boards, role playing, media.

Goal: To Involve School Staff in the Use of Community Health Resources

The goal is for the school staff to be aware of community health resources, of the services provided by each resource, and how to initiate a referral to the community resource which provides assistance for a student's health needs.

The school nurse will consult with and provide information concerning community services available to staff members by:

- Preparing and disseminating a list containing community health resources available to assist with the health needs of students, families, and staff, e.g., American Red Cross, American Cancer Society, American Heart Association (see Section AA of this handbook).

Health Instruction

Section F-2.0

Health instruction is an important component of every student-nurse contact. Health instruction supports public education's goal of preparing a citizen with positive health knowledge which is used to make responsible decisions concerning the care of self, family, and community.

The Professional Nurse Has Three Key Roles in Health Instruction

- To act as a role model of healthful living for the school community.
- To support classroom instruction in select content areas.
- To consult and serve as a resource to students, faculty, and community.

Roles, Competencies, and Activities

Role

The school nurse must act as a role model for healthful living for students, staff, and community.

Competencies

- The nurse must be able to formulate models for healthy behavior derived from scientifically-based literature.
- The nurse must be able to describe, discuss, and explain individual behavior, anatomy and physiology, disease process, and developmental stages when considering healthy behavior changes or attitudes.
- The nurse must be able to demonstrate a commitment to health practices and prevention of poor health by education and example.

Examples of Activities

- Demonstrate infection control measures.
- Promote health weeks.
- Provide safety programs.
- Practice good health behaviors.
- Display health information on bulletin boards.
- Act as a health advocate.

Role

The school nurse must be able to support classroom instruction in select content areas pertaining to health-related material.

Competencies

- The nurse must be able to demonstrate a proficiency to prepare and present health-related material in the classroom to supplement the classroom teacher's curriculum.
- The nurse must be able to demonstrate a proficiency in classroom management.
- The nurse must be able to provide knowledge and understanding of the district's health curriculum, including goals and objectives for student learning.
- The nurse must be able to utilize varied teaching strategies to enhance the learning process.
- The nurse must be able to provide information and promote understanding of developmental stages as they pertain to student health and health instruction.
- The nurse must be able to support classroom curricular by remaining current on health-related research and scientifically-based data.

Examples of Activities

- Teach selected topics, such as cardiopulmonary resuscitation (CPR), first aid, nutrition, body systems, germ theory, communicable disease, health screening procedures, or personal hygiene.
- Participate in continuing education on inservice programs pertaining to teaching techniques, research, or new theories.
- Assist in curriculum development and textbook selection.

Role

The school nurse must act as a health consultant and resource to students, staff, and community.

Competencies

- The nurse must be able to design, plan, and deliver health education programs for students, staff, and community.
- The nurse must be able to formulate and maintain effective working relationships with members of the populations served.
- The nurse must be able to develop a list of available community health education resources.
- The nurse must be able to provide materials and information to supplement the classroom teacher's curriculum.

Examples of Activities

- Provide growth and development films, breast self-exam speakers and film, testicular cancer speakers and film, or courses on babysitting.
- Inform teachers of health-related topics which have been prepared, e.g., CPR, baby care, hypertension.
- Interpret medical problems and care plans for specific health problems, e.g., hemophilia, narcolepsy, sickle-cell anemia.
- Instruct staff on recognition of communicable diseases, e.g., Pediculosis, scabies, chicken pox.

- Describe modes of infection transmission, e.g., hepatitis.
- Develop a list of community resources (see Section AA).
- Accumulate health education information.
- Instruct students in meeting own minor health care needs and personal health assessment, e.g., wound cleansing, application of ice/heat; recording temperature, pulse, respiration, height/weight.

Health Screening

Section F-3.0

The objective of screening students is to detect health problems. A good screening program is rapid and is accepted by the students and staff.

Nurse Responsibilities

- Maintain appropriate equipment for screening.
- Pre-plan with involved teachers prior to the day of screening.
- Obtain or update health history.
- Utilize health screening as a vehicle for one-to-one health counseling and health education.
- Adapt screening tools to appropriate mental age of students.
- Record all findings on health record.
- Record results of follow-up on screening activities (re-test, medical referral, etc.). Screening is of no value without adequate follow-up resulting in appropriate treatment.

Important Things to Remember

- Schedule appropriate time via telephone for parent contact, home visit, parent school visit regarding referrals on all significant health problems.
- Schedule a teacher-nurse conference following student screening to discuss health problems and their educational implications.
- Notify appropriate building staff of students with significant medical problems and health program adjustment.

Physical Assessment

Section F-3.1

A health history should be obtained on all kindergarten students (first grade if this is the entering grade) and on all new students. A more in-depth history is appropriate on students who are candidates for special education or who have continuing health problems.

The following divisions are commonly used in obtaining a patient health history: current health problems, significant past history, review of systems, and family and social history. Although much useful information may be obtained from students, it is usually less complete and accurate than that provided by parents. Always note the source of the information gained and its probable reliability.

Current Health Problems

- Child's general health.
- Absent more than five days of previous or current school year due to illness or accident; type of illness or accident.
- Last seen by a doctor or health clinic; reason.
- Medication taken on regular basis; what; during school hours.
- Known allergies (asthma, hay fever, reactions to drugs or foods).
- Immunizations current.

Significant Past History

- Problems with pregnancy (bleeding or cramping, fever, exposure to infections such as measles, excessive swelling or weight gain); previous number of pregnancies; previous miscarriages; medication taken during pregnancy; use of alcohol or tobacco during pregnancy.
- Labor or delivery difficult or complicated (labor longer than 10 hours, C-section, excessive bleeding, breech presentation, forceps).
- Child breathed immediately after birth and had a good color.
- Child given oxygen or placed in an incubator after birth.
- Birth weight (note if under five pounds).
- Problems in nursery before discharge from hospital.
- Development (indicate month skill attained): walked unassisted; put words together (hi daddy/go bye-bye) with meaning.

Review of Systems

- Vision or hearing problem.
- Convulsive disorder (seizure or epileptic "fit").
- Frequent staring spells or daydreaming.
- Tires easily.
- Recent weight loss (over five pounds) or gain (over ten pounds) in past year.
- Bowel and bladder habits normal.
- Balance and coordination as good as other children of the same age.
- Indication by teacher that the child has difficulty concentrating or paying attention; ability to sit still long enough to watch a 30 minute television program.

Family and Social History

- Number of children in the home; both parents living in the home.
- Upsetting circumstances in the home which might affect the child's school performance.

- Family members who now have or previously had any of the following:

blindness	deaths or degenerative diseases in children or young adults
cerebral palsy	diabetes
learning difficulty (especially reading)	blood dyscrasias
mental retardation	congenital abnormalities
deafness	cardiovascular diseases
seizures/convulsions	other inherited problems
- Other information parent or student may wish to add.

Physical Examination

Section F-3.2

The school nurse must receive specialized training in physical assessment skills before attempting to use special appraisal techniques. Nurses are encouraged to continually practice assessment skills on "normal, healthy" children in order to recognize the comparison of abnormal findings. The physical exam report should include results of previous screenings and available lab reports (see Section F-3.21).

A systematic approach is necessary when doing a physical exam. The preferred method is to start at either the head or the feet, and methodically examine each body part. The four basic physical assessment techniques are: *observation*, *palpation*, *percussion*, and *auscultation*.

Observation

Inspection with the naked eye will give most of the information needed, but tools such as the otoscope and ophthalmoscope will also be helpful.

- Observe general appearance:
 - State of health, integument, growth development, posture, and motor activity.
 - Grooming, personal hygiene, odors, facial expression, awareness, manner, and speech.
- Body symmetry: size, shape, and placement of body parts, scars, birthmarks, masses, or any weaknesses.

Palpation

Includes touching, feeling, noting skin temperature, and vibrations. Use pads of fingers for fine tactile details, back of fingers are most sensitive to skin temperature, and flat of palm and fingers perceive vibrations such as cardiac thrills most accurately.

- Head/neck: Palpate skull for bony configuration, lymph nodes for enlargement, carotid pulses for intensity and symmetry, the position of trachea and size of thyroid gland.
- Face, eyes, ears: Palpate mastoid processes, auricle of ear, sinuses for tenderness.
- Thorax-lungs:
 - Axillary lymph nodes, nipples, chest wall for tenderness.
 - Lungs for vocal tactile fremitus.
- Heart palpate precardium for Point of Maximal Impulse (PMI)—heaves, lifts/thrills.

- Abdomen:
 - Light palpation over all four quadrants for tenderness.
 - Deep palpation for liver, spleen, kidneys.
- Muscles, skeleton: Palpate posterior tibial and dorsal pedis pulses, radial pulses.

Percussion

Helps to determine the density of the underlying parts and whether they are air-filled, fluid-filled, or solid. Percuss over lung fields, abdominal quadrants, borders/span of liver, spleen, and masses.

Auscultation

- Stethoscope: Amplifies and focuses sound over area. Ear pieces cut out other sounds and should fit snugly. Stethoscope should have both bell and diaphragm.
- Auscultate: For breath, heart and bowel sounds, bruits of skull or thyroid, murmur in neck or abdomen, and for friction of ribs.



Section F-3.21

(Indicate abnormality by x)

NAME _____

[illegible]

Growth and Development Screening

Section F-4.0

All children should make gains in height and weight more or less regularly from birth to maturity. Seasonal growth and individual differences in body structure as well as hereditary factors must be kept in mind since there is a variation in children of the same age.

Growth and development are directly related to inherited characteristics and environmental influences throughout the life cycle. Although growth and development generally follow maturational sequences, culture and the quality of the environment exert significant influences on a person's growth and development.

The quality of the environment may directly and/or indirectly influence an individual's growth and development. Physiological needs such as nutrition, sleep and activity; safety needs including protection from elements in the environment such as noise, air and water pollution, crowding and poor sanitation; and the need for love, all influence the individual's growth and development.

Culture may influence growth and development through nutrition, physical/social activities, and stress-handling patterns. Height and weight attainment, as well as disposition to a particular state of health, have their roots in the early developmental period but continue to change throughout the years in school.

Because each individual has a unique interaction with members of the culture and selected aspects of the environment, growth and development patterns may or may not fit into the table or graph of "norms" for each age. Each individual's growth and development should be viewed and assessed according to unique potential relative to cultural and environmental constraints.

Growth and development assessment should be conducted regularly. Notation of head circumference should be made at the initial assessment for baseline establishment. If head development appears unusual, sequential notation should be made. The significance of changing growth and developmental patterns should be discussed with parents in order to promote awareness and responsibility for achieving and/or maintaining optimal health.

Purpose

- To identify the child who is not growing and developing normally.
- To stimulate interest in self-responsibility for growth and development.
- To show relationship between good health practices and growth.
- To create an awareness among school personnel and parents of the relationship of good nutrition to growth.

Procedures and Techniques

- Be sure that scales are in accurate balance.
- Have the student remove shoes, coats, extra sweater, and any heavy objects in pockets.
- Have the student who is not wearing socks place a paper towel on the scale platform before weighing and remove it afterwards. Use measuring board for measuring height.
- Record weight to the nearest pound/half-pound; height to the nearest inch/quarter-inch.
- Students with possible abnormal growth patterns should have height, weight, and head circumference comparisons to age group norms (see tables, Sections F-4.1, 4.2, 4.3, 4.4, 4.5, and 4.6). Those whose height or weight is less than the three percentile or greater than the 97 percentile should be referred to the family physician or a public health clinic.
- A flexible narrow steel tape is recommended for measuring the head circumference. Apply the tape firmly around the child's head above the supraorbital ridges or the most prominent part of the frontal bulge, anteriorly, and over that part of the occiput which gives maximum frontal-occipital circumference.

Follow-Up Procedures

- Confer with teacher and parents; refer children who are gaining or losing weight excessively to family doctor or public clinic.
- Re-weigh students who need follow-up at appropriate intervals.

Suggestions

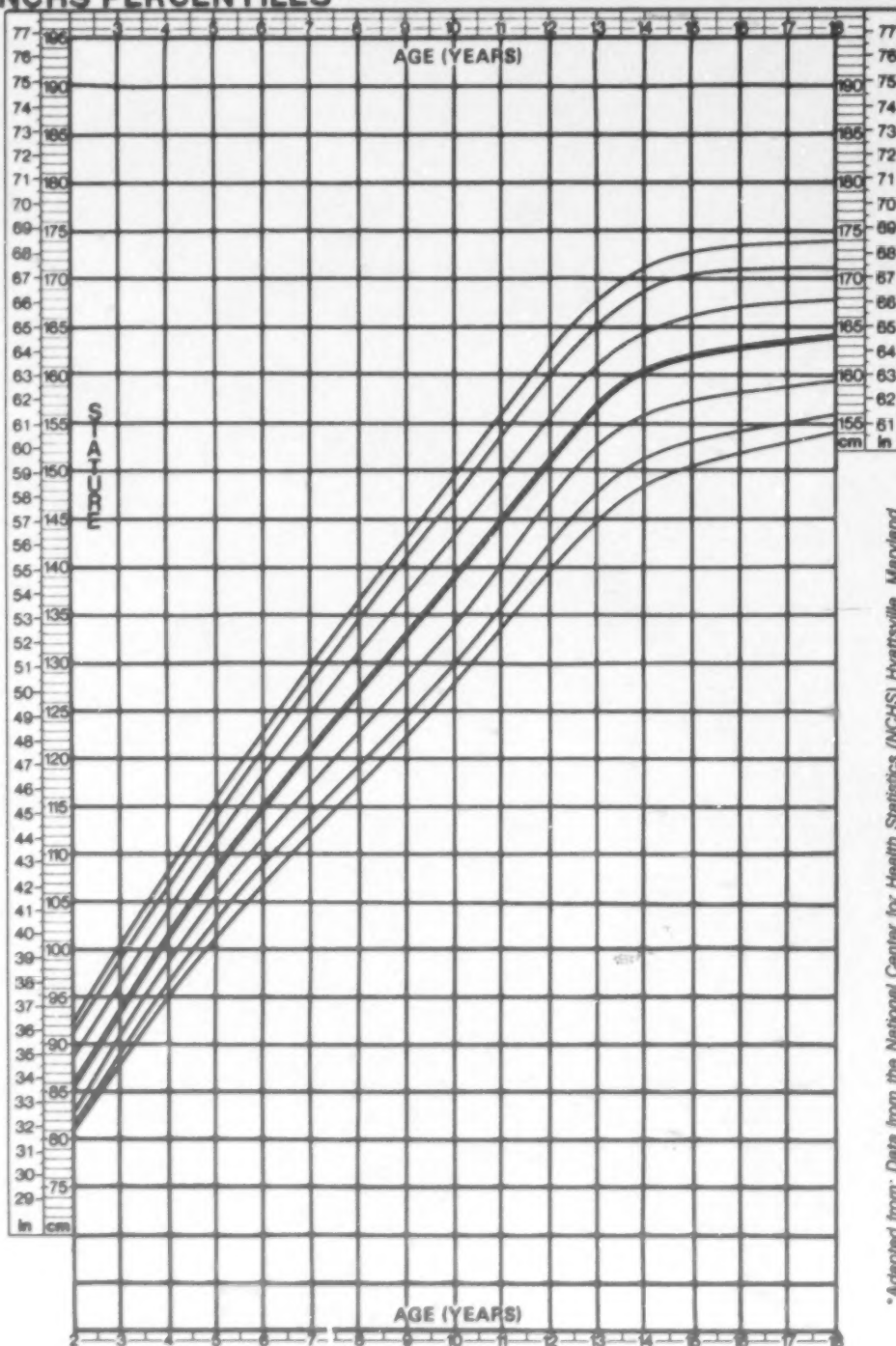
- *Health Instruction:* Weighing and measuring should be accompanied by instruction that capitalizes on normal growth and development.
- *Nutrition Education:* Home economics or health classes in high school and health classes in elementary school may relate nutrition to growth and development.
- *Writing:* The teacher may wish to have the child take home a record of height and weight.
- *Arithmetic:* The measurements of food, especially those concerned with ounce, pound, and half-pound; the average weight of boys and girls; graphs and charts may be used.
- *Spelling:* Learning to spell words concerned with height, weight, and measurement.

Height Chart—Girls

Section F-4.1

GIRLS: 2 TO 18 YEARS
PHYSICAL HEIGHT GROWTH
NCHS PERCENTILES * NAME _____

RECORD # _____



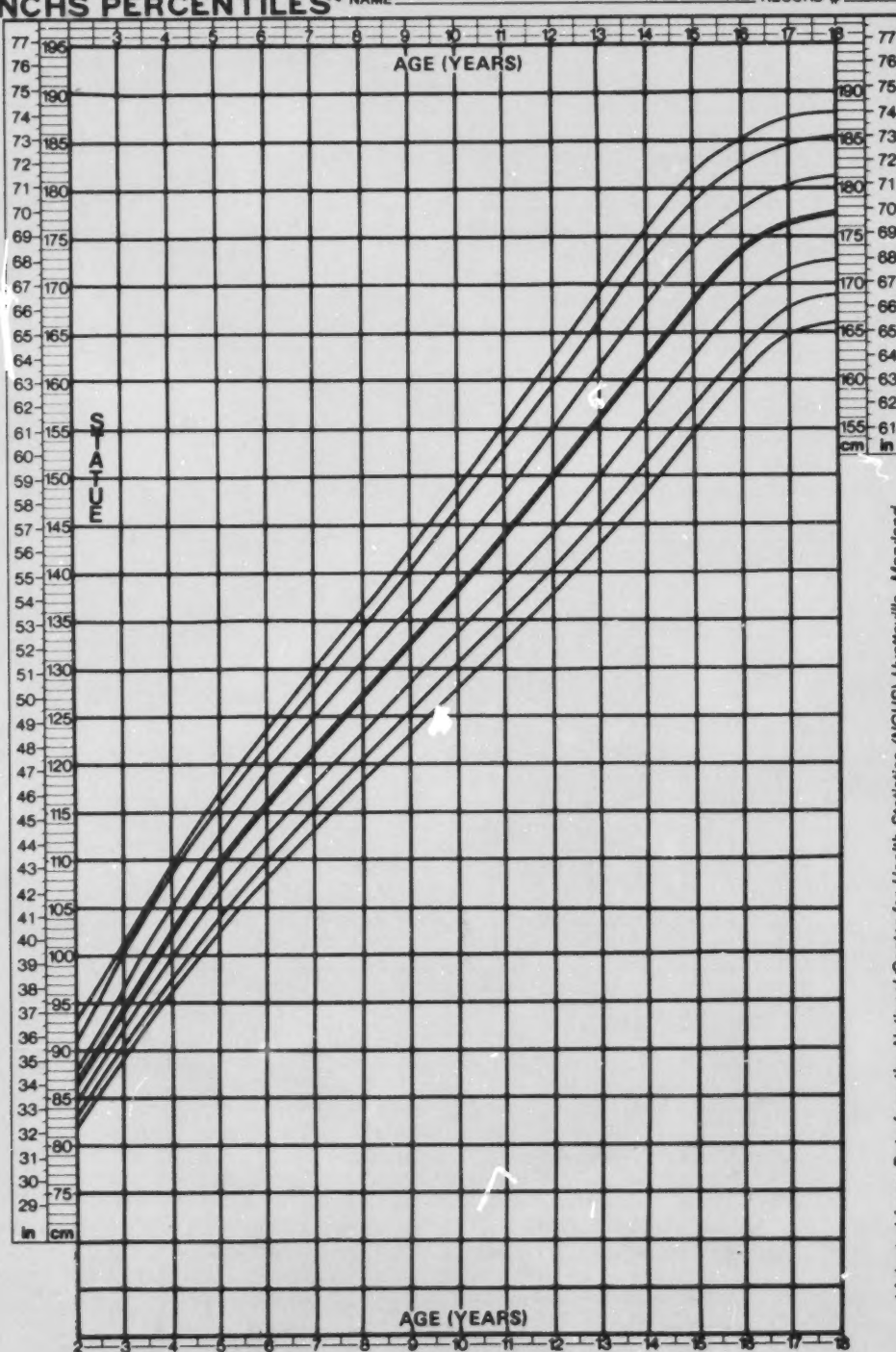
* Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

Height Chart—Boys

Section F-4.2

**BOYS: 2 TO 18 YEARS
PHYSICAL HEIGHT GROWTH
NCHS PERCENTILES*** NAME _____

RECORD # _____



*Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

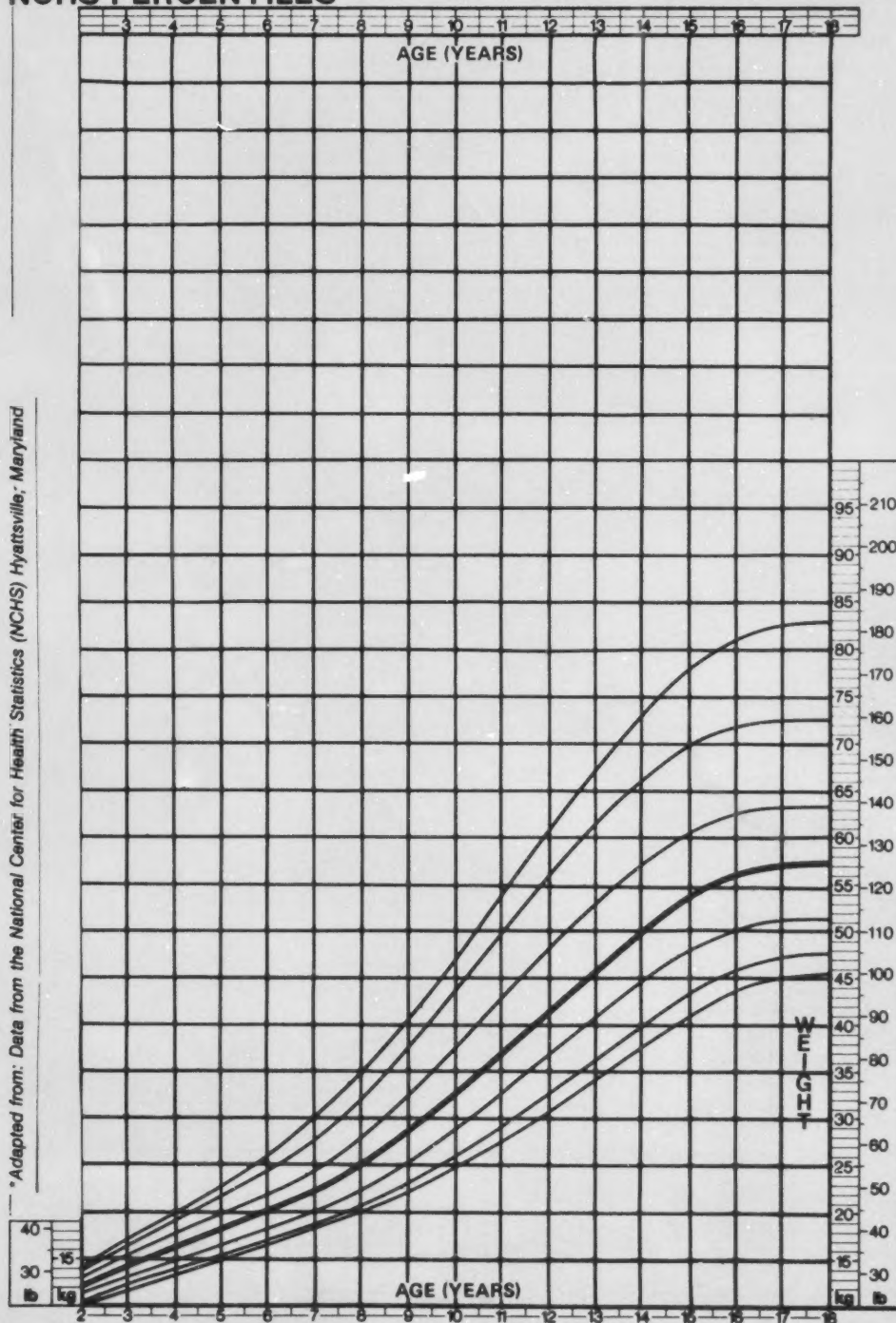
Weight Chart—Girls

Section F-4.3

**GIRLS: 2 TO 18 YEARS
PHYSICAL WEIGHT GROWTH
NCHS PERCENTILES**

* NAME _____

RECORD # _____



* Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

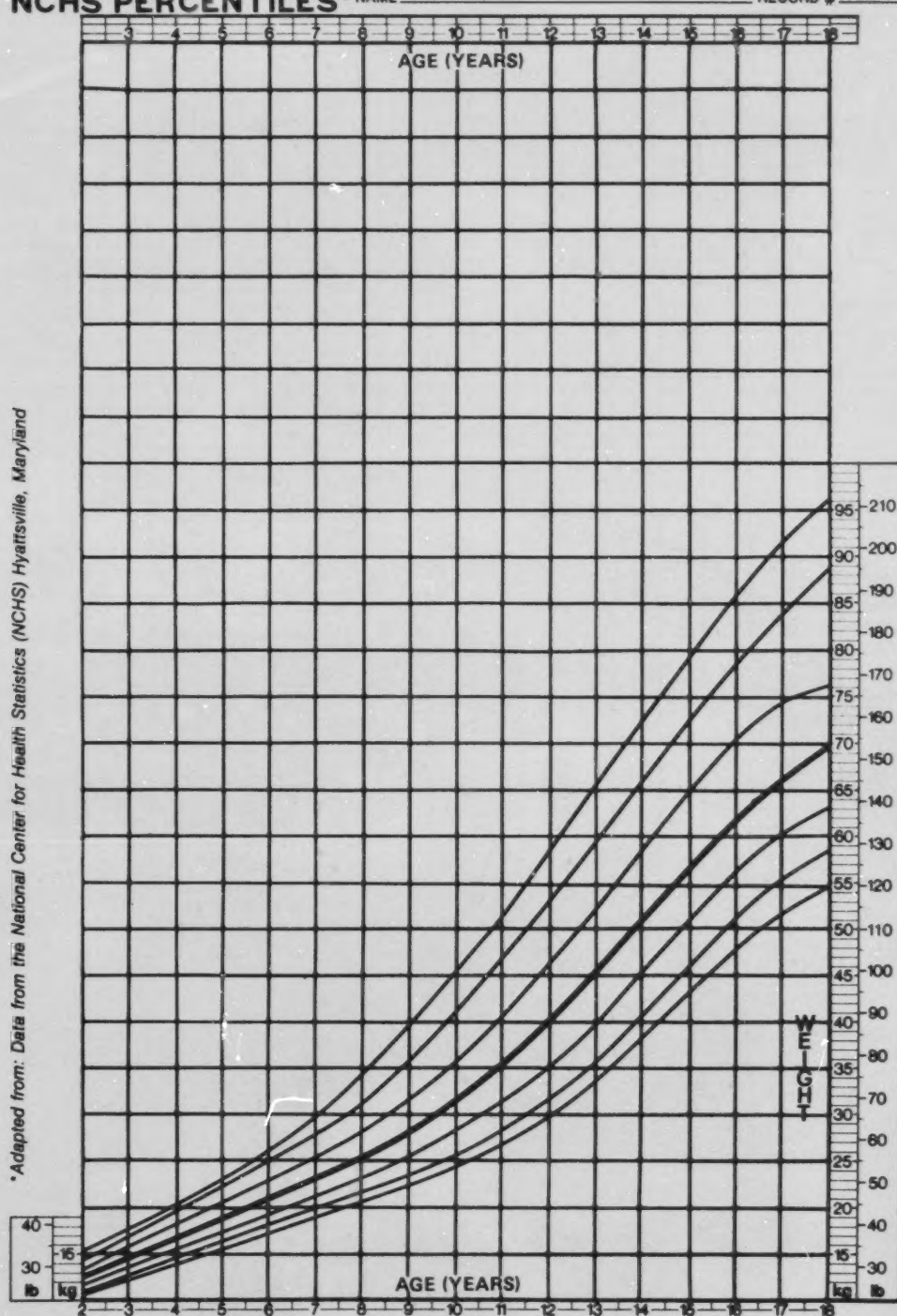
Weight Chart—Boys

Section F-4.4

BOYS: 2 TO 18 YEARS
PHYSICAL WEIGHT GROWTH
NCHS PERCENTILES*

NAME _____

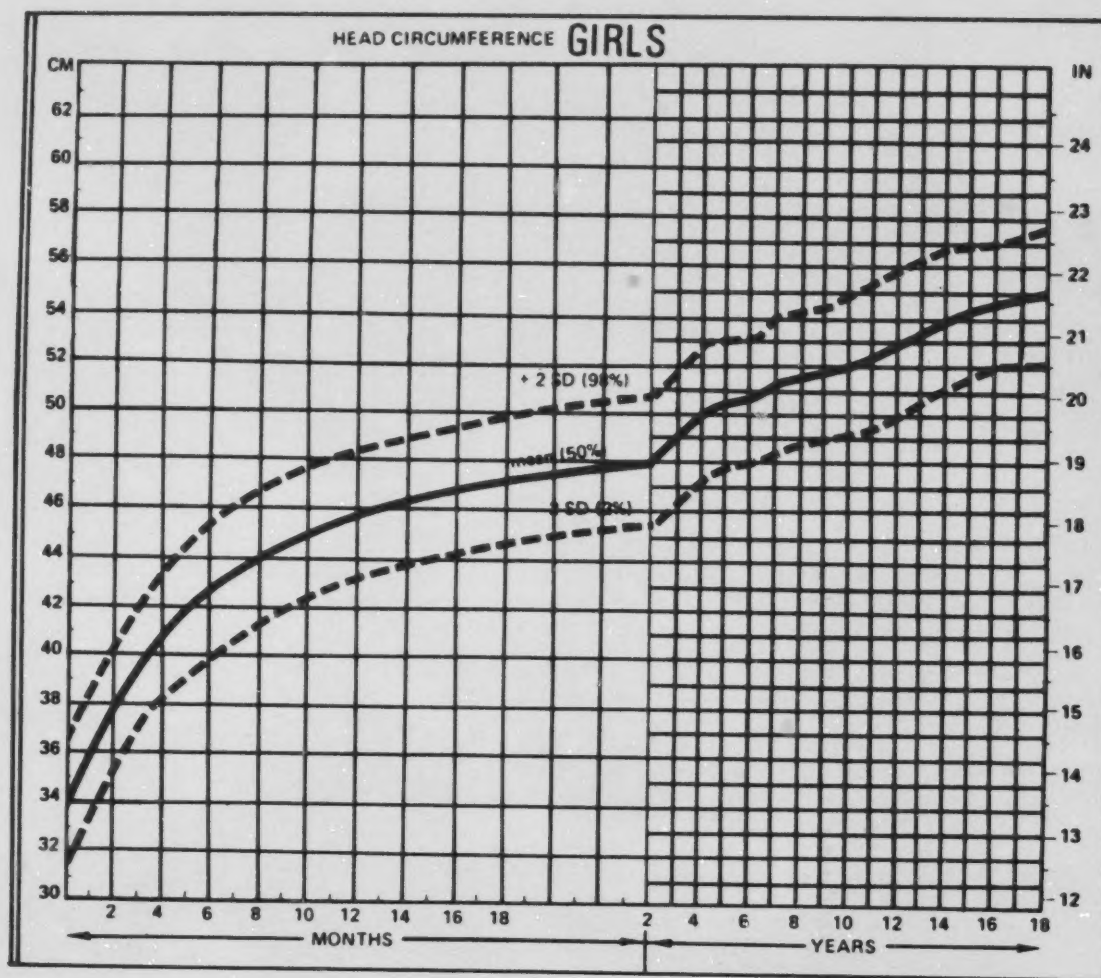
RECORD # _____



*Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

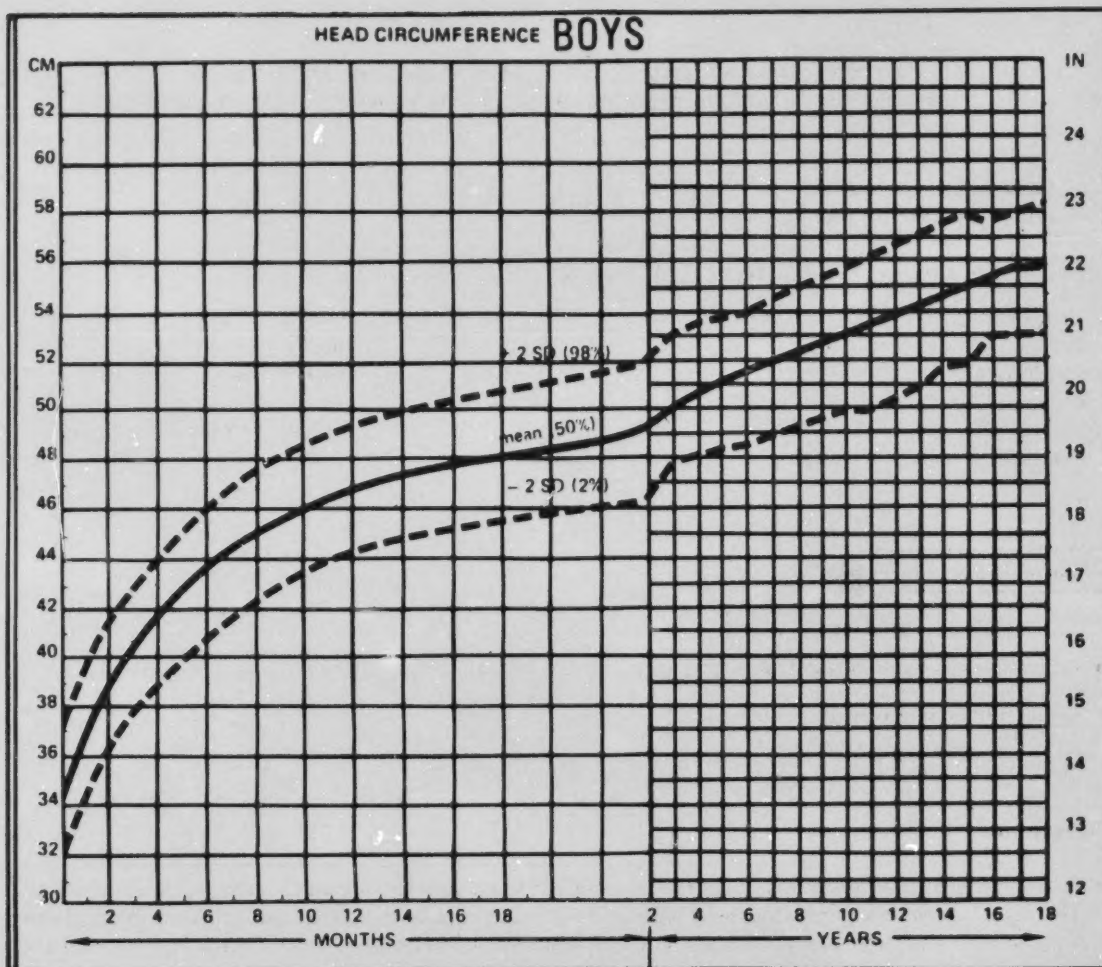
Head Circumference—Girls

Section F-4.5



Head Circumference—Boys

Section F-4.6



Dental Screening

Section F-5.0

Since dental disease affects more students than any other single health problem, it is important that a school health service include dental screening and education. However, students should also be checked by a private dentist at least every six months.

Purpose

The purpose of dental screening is to help educate students about good oral hygiene, to help preserve permanent teeth, to detect abnormalities or problems requiring referral, and to promote general physical health.

Procedures and Techniques

- Use a tongue depressor and adequate light. Look for:
 - abnormalities of mucous membrane
 - caries
 - oral hygiene
 - malocclusions
 - broken teeth
 - retaining temporary teeth (past the age when generally lost)
 - missing permanent teeth
 - supernumerary teeth
 - need for spacer bridge or partial denture
 - dead anterior teeth
 - presence of dental prosthesis

Follow-Up Procedures

- Counsel with the student as needed.
- Notify parent of any dental defect using procedures indicated in referral and follow-up section.
- Assist in obtaining correction of defect, if necessary.

Suggestions

- *Health:* When possible, the dental health education should be planned to coincide with Dental Health Week in February. The nurse, a resource person for the teacher, should assist in planning classroom activities, using filmstrips, large tooth brushes and teeth, and other materials. The Department of Health or Texas Dental Hygienists Association are excellent resources for dental health education.
- *Nutrition:* Health classes in elementary schools may relate nutrition to health, teeth, and gums.
- *Writing:* Teachers may wish to have children keep records of temporary tooth loss related to age or write stories during Dental Health Week.
- *Arithmetic:* Students may be taught the number of permanent teeth in the upper and lower jaws and the approximate age of eruption.
- *Spelling:* Words related to oral hygiene and permanent teeth may be included in spelling lists.

Eruption Table of Teeth

Section F-5.1

- It is as important for the primary teeth to receive proper care as it is to provide proper care for the permanent teeth.
- Teeth begin to develop before the child is born.
- There are twenty of these teeth:
 - 10 in the upper jaw.
 - 10 in the lower jaw.
- Teeth erupt into the child's mouth between the ages of six months and thirty months.

A Full Set of Primary Teeth

With approximate ages at which eruption occurs.

Central Incisor, 7 1/2 mos.

Lateral Incisor, 9 mos.

Cuspid, 18 mos.

First Molar, 14 mos.

Second Molar, 24 mos.



Back of Mouth

Second Molar, 20 mos.

First Molar, 12 mos.

Cuspid, 16 mos.

Lateral Incisor, 7 mos.

Central Incisor, 6 mos.



- If at all possible, each tooth should be retained in the mouth until the permanent tooth is ready to erupt.
- Teeth should be brushed or cleansed immediately after eating. As soon as possible the child should be taught how to brush teeth but, until such time, it should be done by an adult.
- It is necessary for a child's dental health to come under professional supervision of the dentist as soon as possible. If primary teeth are lost prematurely or retained past the normal time any or all of the following conditions may result:
 - Crooked permanent teeth.
 - Irregular and unattractive features when older.
 - Increased cost of dental service.
- If teeth are left unattended, the result may be:
 - Pain for the child (toothache).
 - Sickness for the child (through infections in the mouth).

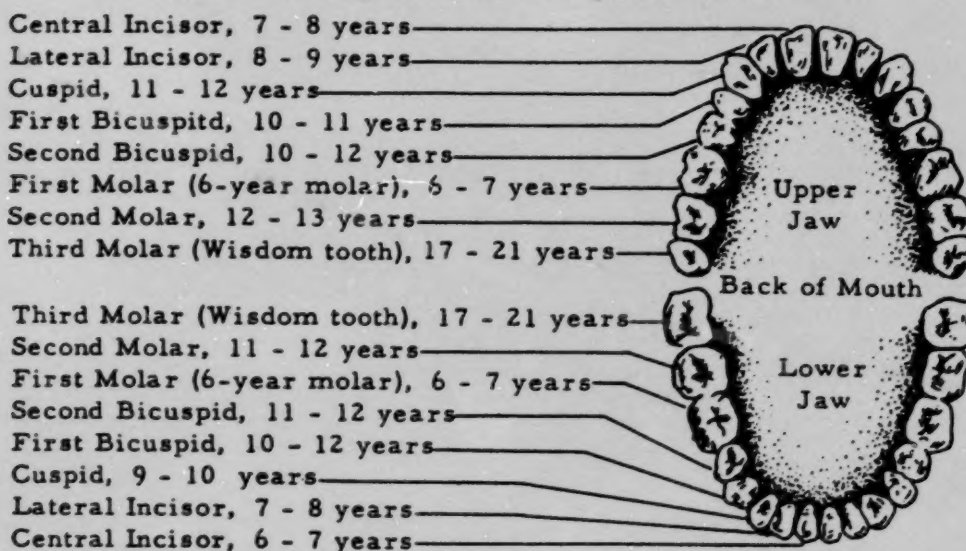
First Permanent Molars

Section F-5.2

- The "six year molars" are the first of the permanent teeth to erupt in the child's mouth.
- There are four of these teeth, one each on the right and left sides of the upper and lower jaws.
- These erupt into the mouth when the child is approximately six years of age.
- Molars appear behind primary teeth, but do not replace them.
- To determine if the child has any or all of these teeth:
 - Start at the center of mid-line of the child's mouth in either jaw.
 - Count, either to right or left of the mid-line, each tooth or space in sequence.
 - If the first permanent molar is present, it will be number six from the mid-line.
- Molars are the "keystones" of the dental arches.
 - Molars help other teeth attain proper alignment.
 - Molars are the sturdiest and largest of any teeth the child will have, so may be used as a guide for other teeth and also as an anchor by the dentist if a child's teeth need to be straightened.
- Losing one or more of these teeth may cause crooked teeth, a deformed mouth, loss of other teeth, infection and/or pain, and unnecessary expense.

A Full Set of Permanent Teeth

With approximate ages at which eruption occurs.



Vision Screening

Section F-6.0

Children entering school for the first time in Texas must have a vision screening, according to the Children's Vision Screening Act of 1979 passed by the Sixty-sixth Texas Legislature. The initial target group includes young children entering kindergarten or first grade and students transferring into Texas schools from other states. The statute requires that all children enrolling in any public, private, parochial, or denominational school for the first time must have an eye examination by a licensed eye specialist or an approved vision screening test. The Basic Visual Acuity Test and Referral Criteria, recommended by the Advisory Committee on Children's Vision and approved by the Texas Board of Health was implemented statewide on September 1, 1980 (see Section F-6.1).

Purpose

The purpose of a vision acuity screening program is to: identify through mass screening any student with vision difficulty, to test further and evaluate those students who failed the initial screening; and to refer for additional examination and possible treatment, if indicated. It is recognized that much learning is acquired through the sense of sight, and any undetected and uncorrected visual defect may affect a student's entire adjustment in school.

Snellen Eye Chart Procedures and Techniques

Screening should be done in a quiet area free from disturbances. When Snellen charts are attached to a wall, the surrounding area should be uncluttered. Use "butcher paper" or other brown paper to cover patterned walls if necessary.

Lighting at the chart should be normal and free of shadows or glare. Illumination on the chart should measure between 10 and 30 footcandles with ambient room lighting no less than one-fifth the amount on the chart. In darker locations or on cloudy days, supplemental lighting with one or two gooseneck lamps may be necessary. (Self-illuminated charts are designed to provide accurate light values.)

The line for referral (20/40 or 20/30) should be on an eye level with the child seated or standing.

A 20-foot distance from the child to the eye chart is preferred. Space limitations or poor testability of the child may dictate the choice of models scaled for use at 10 feet. Charts designed for use at 20 feet should never be used at 10 feet and vice versa.

Linear test procedures are preferred (exposing one line of letters or symbols at a time). Isolated test procedures (a single letter or symbol) are approved according to the sequence shown on the Basic Visual Acuity Tests and Referral Criteria form.

Approved Charts for Basic Visual Acuity Testing

- Snellen Letter Chart (20-foot and 10-foot models).
- Snellen "Tumbling E" Chart (20-foot and 10-foot models).
- HOTV Matching Symbol Test (the 10-foot model only).

All new students must be screened within 90 days for first entry into the school system.

Ideally, all students would be screened for vision and hearing annually. Vision should be tested through grade 10 and may be alternated yearly with hearing screening. In addition, screening should include: students in special education classes; those referred by parent, counselor, or teacher; and those with known vision problems, including those previously referred for follow-up and who did not receive care. Local school district policy should determine grades designated for vision screening. Reporting form samples are provided in Sections F-6.2 and 6.3.

Follow-Up Procedures

The nurse will:

- Notify parents, and refer for evaluation and follow-up students whose visual acuity is below standards.
- Counsel with the parent and assist with or arrange for the correction or treatment of any defect.
- Refer student for placement in special education classes for visually handicapped, if eligible.
- Notify teachers and suggest students be given preferential seating in the classroom, where appropriate.

Suggestions

- *Health Education:* The importance of eye care through rest, lighting, and eye protection should be stressed.
- *Nutrition:* Teaching good nutrition for body growth and maintenance for all body systems is an integral part of student education.
- *Arithmetic:* Teach students the distances used for vision screening and the significance of the numerical findings on a Snellen chart.
- *Spelling:* Older students may be taught the definition and spelling of words such as: iris, pupil, conjunctiva, sclera, cornea, and lens.

Basic Visual Acuity Test and Criteria

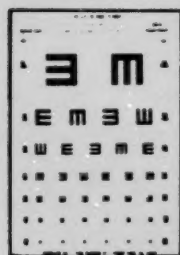
Section F-6.1

TEXAS DEPARTMENT OF HEALTH

BASIC VISUAL ACUITY TESTS AND REFERRAL CRITERIA

IMPORTANT INFORMATION: The preferred distance visual acuity test is given with a Snellen Chart at 20 feet, using the linear test method. Below are criteria for various age groups as approved by the Advisory Committee on Children's Vision. When a child cannot be tested by the preferred method, test according to the sequence shown below, for the appropriate age, before considering the child not testable. In limited space, a 10-foot chart may be used; however, care should be taken that screeners never use a 20-foot chart at a distance of 10 feet. When using HOTV matching symbols, only the 10-foot HOTV is approved. If stereoscopic instruments are used to test visual acuity, use the same referral standards as shown below; however, children failing such testing should be re-screened with an approved chart, at distance, before being referred. REGARDLESS OF THE RESULTS OF ANY SCREENING TEST, OBSERVATION OF OBVIOUS SIGNS OF EYE PROBLEMS WOULD BE THE BASIS FOR REFERRAL FOR A PROFESSIONAL EYE EXAMINATION.

Tests for Ages 3 & 4

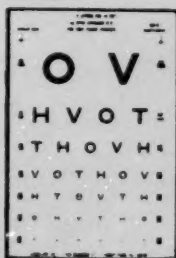
"Tumbling E"

linear @ 20'

isolated @ 20'

linear @ 10'

isolated @ 10'

H:O:T:V Test

@ 10'

Referral Standards

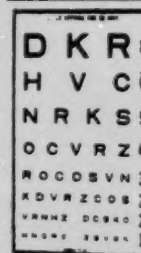
All children should be screened thru the 20/20 line. Must read a majority (one more than half) of the 20/40 line, or 4 out of 6 HOTV symbols (of 20/40 size). Children with a two-line difference between the two eyes should be referred.

Tests for Age 5

(SAME AS: Ages
3 & 4.)Referral Standards

Must read majority of 20/30 line, or 4 out of 6 HOTV symbols of that size.

Tests for Ages 6 & Up

Letter Chart

linear @ 20'

"Tumbling E"

linear @ 20'

isolated @ 20'

linear @ 10'

isolated @ 10'

H:O:T:V Test

@ 10'

Referral Standards

Must read majority of 20/30 line, or 4 out of 6 HOTV symbols of that size.

REFER AFTER SECOND SCREENING

M-61 1980

Sample: Vision Screening and/or Eye Examination

Section F-6.2

**TEXAS DEPARTMENT OF HEALTH
VISION SCREENING and/or EYE EXAMINATION**

ATTENTION PARENT: Please present this certificate when enrolling your child in school for the first time. Article 4419f, Texas Revised Civil Statutes, requires that every child have an eye examination or approved vision screening test prior to, or within 90 days after, entry into a Texas school.

SCHOOL _____ CITY _____ COUNTY _____

Child's Name _____ Birth Date _____ Age _____ Sex _____

Parent's Name _____ Telephone Number _____

Address _____ Zip Code _____

VISION SCREENER REPORT

Visual acuity screening is only a check of the sharpness of a child's vision and should not be interpreted as a substitute for a complete vision examination. A child who fails this screening should be referred to an eye specialist for a complete visual examination.

VISUAL ACUITY
First test

Screened with glasses? Yes ☐
No ☐

SCREENING RESULTS

Right Eye 20/

Left Eye 20/

☐ Snellen Chart
☐ Other: _____

(instrument)

PASSED ☐

FAILED ☐

Second test

Right Eye 20/

Left Eye 20/

☐ Snellen Chart
☐ Other: _____

PASSED ☐

FAILED - REFERRED ☐

Observable Signs _____

Other Test(s) _____

Reason for referral to Eye Specialist _____

DATE _____ VISION SCREENER _____ ORGANIZATION RESPONSIBLE FOR SCREENING _____

**EYE SPECIALIST REPORT
(Ophthalmologist or Optometrist)**

VISUAL ACUITY

Without correction

With correction

RIGHT EYE

20/

20/

LEFT EYE

20/

20/

Problem(s) noted: _____

PLEASE CHECK IF APPROPRIATE:

Recommendations:

☐ Medical evaluation

☐ Glasses

☐ Contact Lenses

☐ Other: _____

Re-examination advised

☐ Six months

☐ Twelve months

☐ Other: _____

Corrective Lens prescribed

Constant Wear

Near Vision only

Far Vision only

May be removed for physical education

Please print or stamp

Doctors Name: _____

Address: _____

City: _____

Present Date _____

Date of last examination _____

DOCTOR'S SIGNATURE _____

1980

Please retain this certificate with other health records of the child.

White — School (Child's Health Record). Canary — Health Department. Pink — Screening Organization.

M-60

Sample: Vision Screening Annual Report

Section F-6.3

TEXAS DEPARTMENT OF HEALTH

FOR INSTRUCTIONS:
See back of this form.

VISION SCREENING REPORT FOR SCHOOL YEAR 19__--19__

HEALTH
SCREENING
FACILITY _____

CITY _____

COUNTY _____

GRADES	A TOTAL NUMBER SCREENED	B SCREENED WITH GLASSES*	C NUMBER FAILED	D FAILED NOT REFERRED	E EXAMINED BY EYE SPECIALIST NO PROBLEM/ NO TREATMENT	F TREATMENT OR OBSERVATION	G REFERRED, NO FOLLOW-UP
PRE- SCHOOL							
SPECIAL EDUC.							
K							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

C = D + E + F + G

TOTALS	A	B	C	D	E	F	G

TOTAL EXAMINED BY EYE SPECIALIST
(E + F)

*This number is included in the total number screened and is, therefore, a smaller number.

To be submitted by: JUNE 30, 19__

To: Vision, Hearing and Speech Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756
(512) 458-7420

CHIEF ADMINISTRATOR'S SIGNATURE _____

CHIEF ADMINISTRATOR'S TITLE _____

DATE _____

M-62 (1983)

(Back of Report)

INSTRUCTIONS

VISION SCREENING REPORT FOR SCHOOL YEAR 19__--19__

Reporting Period: September through August of the year prior to the Reporting Date

Reporting Date: June 30th following the Reporting Period

EXPLANATION OF COLUMNS

Grades: This column is self-explanatory. For preschools and other organizations screening preschool-aged children, simply enter totals on the line for Preschool and enter those same totals on the TOTAL line.

Total Number Screened: Total number screened during the Reporting Period at each grade level

Screened With Glasses: Number screened with glasses on (This number is a part of the total number screened.)

Number Failed: Number who failed the screen or were referred for observable signs or symptoms. (This number should include those who fail other types of vision screens such as those used with stereoscopic instruments or other procedures, and at this time failure is determined by referral criteria associated with the particular screen.)

Failed Not Referred: Those who failed but are currently under an eye specialist's care OR those who have an uncorrectable condition (enucleated eyeball, etc.)

Examined by Eye Specialist: After examination by an eye specialist the following breakdown of results should be reported:

No Problem/No Treatment: Those referred who had no visual problem or who received no treatment for an existing condition

Treatment or Observation: Those referred who are receiving treatment from an eye specialist or whose conditions are being observed for a period of time

Referred, No Follow-Up: Those referred who did not see an eye specialist or who were lost to the screening program (This simply means that follow-up was not possible because either the person referred did not see an eye specialist or the information on the referral was unobtainable.)

REMEMBER: Calculate totals for each column at the bottom of the form and CHECK those totals using the simple formula given, $C = D + E + F + G$.

Also, note that columns E and F should be added together for a Total Number Examined by Eye Specialist.

Any questions about the proper use of this form can be directed to:

Vision, Hearing and Speech Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756
(512) 458-7420

M-62 (1983)

Audiometric Screening

Section F-7.0

Audiometric Screening Consists of Three Methods of Testing

- Sweep-Check
- Puretone-Threshold
- Impedance

The Sweep-Check is a rapid screening test designed to identify students needing further examination. The Puretone-Threshold screening test, a more refined exam, is designed to determine the lowest intensity level of hearing acuity in each frequency. The Impedance test measures the transfer of sound energy across the middle ear mechanism. The resulting tympanogram reveals information about the condition of the middle ear.

Only audiologists, speech pathologists, or nurses with explicit training in the use of acoustic impedance audiometry should use this method of audiometric screening in the school.

Kindergarten and first and second grade children should be screened for hearing once a year. In the higher grades, vision and hearing tests may be alternated through the 11th grade. In addition, audiometric screening should include: students in special education classes; those referred by parent, counselor, or teacher; those known to have frequent ear infections; and those referred for follow-up who did not receive care. Local school district policy should determine grades designated for audiometric screening.

Purpose

- To identify through mass screening any student with possible hearing impairment.
- To identify the hearing-impaired child during early school years.
- To identify older students who have impaired hearing due to noise assault.
- To refer students for further audiometric screening or for medical evaluation and treatment.
- To teach hearing conservation and protection.

Procedures and Techniques

- The nurse should test the audiometer accuracy once a month.
- Students with draining ears or ear infections should be tested at a later date.
- Students wearing hearing aids should not be administered Sweep-Check or Puretone tests.
- The test location should provide the lowest noise level possible.
- Familiarize students with procedure, equipment, sounds, and expectations before testing.
- One-day hearing screening workshops are provided on a statewide basis by personnel from Vision, Hearing, and Speech Services or other Texas Department of Health-approved trainers. These workshops consist of half a day of lecture and half a day of practicum training in the use of the audiometer for screening. The practicum and a written test are carried out under the supervision of trained instructors. Guidelines are provided by the Texas Department of Health—Vision, Hearing, and Speech Services.

Follow-Up Procedures

- A student who fails to respond in either ear to two or more frequencies at 25 decibels, ANSI, should be re-tested at a later date.
- Students who fail audiometric re-testing should be referred to the school audiologist, private physician, or community service. The audiogram should be provided to the referral agency.
- Teachers should be notified when students need preferential seating in the classroom.
- Families who cannot afford medical care should be referred to the Texas Department of Health, Division of Services for Crippled Children.
- Children with hearing problems, who cannot afford medical care, which require a hearing aid should be referred to the Texas Department of Health, Bureau of Maternal and Child Health—Vision, Hearing, and Speech Services.

Suggestions

- *Health Education:* In elementary schools, the nurse may include ear models, ear plugs, hearing aids, and an audiometer in classroom presentations. Discussions should include ear protection, noise levels or pollution, understanding of hearing loss, and hearing conservation. In secondary schools, nurses should also present information on audio protection from noise assault caused by loud machinery, musical amplifiers, musical headsets, hunting with guns, and motorcycles. All students should be taught not to put objects into ear canals. Outer ear cleaning is sufficient. Canal cleaning should only be done by physicians.
- *Arithmetic:* Elementary classroom presentation might include the decibel levels and frequencies used in audiometric screening.
- *Spelling:* Include anatomy of the ear with specialized words in spelling lists.

Factors Influencing Hearing/Types of Hearing Losses

- *Conductive:* Sound cannot reach the inner ear. Colds and allergies may cause temporary losses of this type.
- *Sensori-Neural:* A defect resulting from damage to the auditory nerve or brain.
- *Mixed:* A combination of conductive and sensory factors.

Conditions and Illnesses Affecting Hearing

- CONGENITAL DEAFNESS, SENSORI-NEURAL is caused frequently by illnesses in the first trimester of pregnancy (German measles, for example).
- HEREDITARY DEAFNESS is not rare. The cause is unknown.
- ACQUIRED DEAFNESS or hearing impairment may be caused by:
 - Meningitis, encephalitis, and other central nervous system infections.
 - Infections with neurotropic viruses such as mumps.
 - Infections of the ear—otitis media, mastoiditis.

- Toxic agents, such as nicotine, aspirin, streptomycin, neomycin, etc.
- Enlarged tonsils and adenoids, sinusitis, allergic rhinitis.
- Mechanical injury, including skull fracture; sustained environmental noise above 85 dB or loud impulse noise (rivet gun, air wrench, shotgun, rifle, etc.).
- Otosclerosis.
- Psychogenic (hysterical: conversion reaction).
- Central deafness, normal sense organ, and auditory nerve with impairment in the brain, i.e., tumors, cerebral hemorrhage.

Relationship of Degree of Impairment to Educational Needs Section F-7.1

Average of the Speech Frequencies in Better Ear	Effect of Hearing Loss on the Understanding of Language and Speech	Educational Needs and Programs
SLIGHT 27 to 40 dB (ISO/ANSI)	May have difficulty hearing faint or distant speech. May experience some difficulty with the language arts subjects.	Child should be reported to school principal and/or teacher. May benefit from a hearing aid. May need attention to vocabulary development. Needs favorable seating and lighting. May need lipreading instructions. May need speech therapy.
MILD 41 to 55 dB (ISO/ANSI)	Understands conversational speech at a distance of 3-5 feet (face to face). May miss as much as 50% of class discussions if voices are faint or not in line of vision. May exhibit limited vocabulary and speech anomalies.	Child should be referred to special education for educational follow-up. Individual hearing aid after evaluation and training in its use. Favorable seating and possible special class placement, especially for children in primary grades. Attention to vocabulary and reading. Lipreading instruction. Speech conservation and correction, if indicated.
MARKED 56 to 70 dB (ISO/ANSI)	Conversation must be loud to be understood. Will have increased difficulty in group discussions. Is likely to have defective speech. Is likely to be deficient in language usage and comprehension. Will have limited vocabulary.	Child should be referred to special education for educational follow-up. Resource teacher or special class. Special help in language skills: vocabulary development, usage, reading, writing, grammar, etc. Individual hearing aid after evaluation and auditory training. Lipreading instruction. Speech conservation and correction. Attention to auditory and visual situation at all times.

Relationship of Degree of Impairment to Educational Needs (Continued)

Average of the Speech Frequencies in Better Ear	Effect of Hearing Loss on the Understanding of Language and Speech	Educational Needs and Programs
SEVERE 71 to 90 dB (ISO/ANSI)	May hear loud voices about one foot from the ear. May be able to identify environmental sounds. May be able to discriminate vowels but not all consonants. Speech and language defective and likely to deteriorate.	Child should be referred to special education for educational follow-up. Full time special program for deaf children, with emphasis on all languages skills, concept development, lipreading, and speech. Program needs specialized supervision and comprehensive supporting services. Individual hearing aid after evaluation. Auditory training with individual and group aids. Part time in regular classes only as is profitable.
EXTREME 91dB or more (ISO/ANSI)	May hear some loud sounds but is aware of vibrations more than tonal pattern. Relies on vision rather than hearing as primary avenue for communication. Speech and language defective and likely to deteriorate.	Child should be referred to special education for educational follow-up. Full time in special program for deaf children, with emphasis on all language skills, concept development, lipreading, and speech. Program needs specialized supervision and comprehensive supporting services. Continuous appraisal of needs in regard to oral and manual communication. Auditory training with group and individual aids. Part time in regular classes only for carefully selected children.

Source: Adapted from a compiled study in Illinois Commission on Children, 1968, p. 19.

Hearing Conservation Program

Section F-7.2

Audiometer User Registration

Audiometer user registration is required under the Texas Regulations for the Control of Infrasonic, Sonic, and Ultrasonic Radiation. Specifications for registration can be met in two ways: an individual may qualify for registration (1) upon completion of six semester hours of audiology from an accredited institution, or (2) upon completion of a state-approved hearing screening workshop. (Physicians and licensed hearing aid dealers may be registered without prerequisite training.) A sample user registration form is provided in Section F-7.21.

Audiometric Workshops

Screening Workshops: One day screening workshops are provided on a statewide basis by personnel from Vision, Hearing, and Speech Services or other Texas Department of Health-approved trainers. These workshops consist of half a day of lecture and half a day of practicum training in the use of the audiometer for screening. The practicum, including a written test, is carried out under the supervision of the instructors.

Trainer Orientation Workshops

These workshops, provided by Vision, Hearing, and Speech Services, train persons who will conduct screening workshops throughout the state. Emphasis is on general format, materials, and techniques to be used by instructors. Equipment, materials, and required forms are provided.

Audiometer Registration

- The provisions of the *Texas Regulations for the Control of Infrasonic, Sonic, and Ultrasonic Radiation* also require registration of:
- All audiometers: Biological calibration monthly, electronic calibration annually, exhaustive electronic calibration at least every 5 years, all to current ANSI standards (see Section F-7.22).
 - All calibration firms: Calibration equipment, calibration technicians, training approved by, file reports as directed by the Texas Department of Health.

Current Registration Number
(New Applicant Disregard)

(NOTE: This form will be copied as your REGISTRATION -- Please type or print plainly, in BLACK ink.)

TEXAS DEPARTMENT OF HEALTH

USER OF AUDIOMETER REGISTRATION FORM

APPLICANT'S NAME (First Name First)

APPLICANT'S ADDRESS (Street)

EMPLOYER (Full Designation of Applicant's Fiscal Agent)
(If school please state whether Co-op, ISD, Consol., etc.)

EMPLOYER'S CITY

STATE

ZIP CODE

EDUCATIONAL TRAINING (University, College or School Attended)

DATES

DEGREE(S) EARNED

APPLICANT'S TITLE

APPLICANT'S CITY

STATE

ZIP CODE

EMPLOYER'S ADDRESS (Street)

EMPLOYER'S TELEPHONE (Area Code + Number)

List Specific Audiometric Screening or Testing Courses Completed Under EDUCATIONAL TRAINING:

ADDITIONAL AUDIOMETRIC TRAINING:

AGENCY	NUMBER OF HOURS	DATE	CITY
Texas Dept. of Health			
OSHA			
Seminar			
Other			

APPLICANT WILL USE AUDIOMETERS IN: (Check Applicable Boxes) - Item

School Screening ☐ ; Speech Pathology ☐ ; Medical Research ☐ ;
 Speech & Hearing Clinic ☐ ; Educational Training ☐ ;
 Industrial Screening (OSHA) ☐ ; Medical Diagnostic ☐ ;
 Fitting & Dispensing of Hearing Aids ☐ ; Health Agency ☐ ;
 Other

FORMS MAY NOT BE REPRODUCED FOR APPLICATION USE
Additional Forms May be Requested

TRC Form 130-1, Part 1 (9-77)
Supersedes all previous TRC Forms 130-1, Part 1

AGENCY USE ONLY: REGISTRATION NUMBER

In accordance with statements and representations contained in this application, you are hereby registered to use audiometers (as indicated in ITEM 7) in the State of Texas.

D. K. Ozias, Ph.D., Director of Programs
Speech, Hearing and Vision
Division of Maternal and Child Health

Date:

Texas Department of Health

Texas Department of Health

Section F-7.22

Audiometer/Impedance Bridge Registration Application

TEXAS DEPARTMENT OF HEALTH

Audiometer/Impedance Bridge Registration Application

INSTRUCTIONS ON REVERSE

1. NAME OF OWNER		2. ADDRESS	
3. ADDRESS OF USE (if different from #2)		4. TELEPHONE NUMBER	
5. AUDIOMETER USAGE (check appropriate space(s)) school agency___; speech pathology___; health agency___; educational training___; industrial screening (OSHA)___; medical-research___; medical-diagnostic___; fitting & dispensing of hearing aids___; speech & hearing clinics___; other_____			
6. DEPARTMENT OF USE:			
7. INDIVIDUAL(S) IN CHARGE OF UNIT AND TITLE:			
IDENTIFICATION			
8. MANUFACTURER:		9. MODEL NUMBER:	
		10. SERIAL NUMBER:	
11. TYPE OF CUSHIONS (check one): MX-41AR___; AURAL DOMES___; OTO CUPS___; AUDIO CUPS___; OTHER_____		12. DATE OF LAST CALIBRATION:	
13. CALIBRATED BY (firm name and address):			
14. APPLICATION DATE:		15. PRINTED NAME:	
		16. TITLE:	
17. SIGNATURE:			

RC Form 130-1, Part 2 (1-81) Supersedes all previous RC Forms 130-1, Part 2
 GENCY USE ONLY:

In accordance with statements and representations contained in this application, this audiometer/impedance bridge is hereby registered (as specified in ITEM 5 above) by the State of Texas.

D. K. Ozlas, Ph.D., Director of Programs
Vision, Hearing and Speech Services
Division of Maternal and Child Health

REGISTRATION NO. _____

DATE _____

TEXAS DEPARTMENT OF HEALTH

(Back of Application)

**INSTRUCTIONS FOR AUDIOMETER/IMPEDANCE BRIDGE REGISTRATION APPLICATION
(TRC Form 130-1, Part 2)**

PLEASE PRINT NEATLY IN BLACK INK OR TYPE ALL INFORMATION.
(Your registration will be a copy of this form.)

NOTE: Your care in completing all required information in this application may save undue delay and reduce the amount of correspondence necessary. Your cooperation is earnestly solicited.

1. NAME OF OWNER: The name of the facility owning or leasing the audiometer/impedance bridge, or the name of the individual if the audiometer/impedance bridge is personally owned.
2. ADDRESS: Address of owner named in Item 1. Address must include city and zip code.
3. ADDRESS OF USE: Self-explanatory.
4. TELEPHONE NUMBER OF APPLICANT: Telephone number of owner named in Item 1 at place of employment; include area code.
5. AUDIOMETER/IMPEDANCE BRIDGE USAGE: Check appropriate space(s).
6. DEPARTMENT OF USE: Indicate specific office that audiometer/impedance bridge is used: i.e., Black and White Steel Mill - First Aid Station.
7. INDIVIDUAL(S) IN CHARGE OF UNIT AND TITLE: Individual(s) with administrative responsibility for use of the audiometer/impedance bridge and given title(s).
8. MANUFACTURER: Company that made the audiometer: i.e., Beltone, Maico, etc.
9. MODEL NUMBER: Manufacturer's model designation number: i.e., 9D, MA-2, etc.
10. SERIAL NUMBER: Manufacturer's serial number: NOT A LOCALLY ASSIGNED INVENTORY OR OTHER RECORD NUMBER! (Serial number is usually found on data plate next to model number.)
11. TYPE OF CUSHIONS: Type of cushions on earphones; check appropriate space.
12. DATE OF LAST CALIBRATION: Self-explanatory.
13. CALIBRATED BY: List the name and address of the firm that last calibrated the audiometer/impedance bridge.
14. APPLICATION DATE: Date form is completed by applicant listed in Item 1.
15. PRINTED NAME: Printed name of individual submitting application.
16. TITLE: Title of individual listed in Item 15.
17. SIGNATURE: Signature of individual listed in Item 15. Must be signed in black ink.

BE SURE TO REGISTER ALL AUDIOMETERS/IMPEDANCE BRIDGES USED. SEPARATE FORMS ARE REQUIRED FOR EACH AUDIOMETER/IMPEDANCE BRIDGE REGISTERED. FORMS MAY NOT BE REPRODUCED FOR APPLICATION USE. ADDITIONAL FORMS MAY BE REQUESTED FROM THIS DEPARTMENT.

MAIL THIS APPLICATION TO: Texas Department of Health
Vision, Hearing and Speech Services
1100 West 49th Street
Austin, Texas 78756

Scoliosis Screening

Section F-8.0

Scoliosis is a lateral curvature of the spine, most commonly found during the adolescent growth period. It is estimated that between five and ten percent of school children have a curvature in varying degrees. However, only about two percent are significant. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly treatment is received.

Scoliosis is more common in girls than in boys. The malformation tends to progress no further once the spine has reached full growth, about the age of 15 for girls or 17 for boys.

Purpose

The purpose of scoliosis screening is the early detection and referral of spinal variations which may or may not be progressive. If detected early, a vertebral curvature may be controlled. Any spinal deviation of a student should be referred by the school nurse for follow-up care by the family physician, orthopedist, public clinic, or hospital.

Nurse Responsibilities

The school nurse must be well prepared to provide the maximum benefit for the students in a scoliosis screening program. Grades five through nine should be screened.

- Orient the school staff, parents, and students to scoliosis screening procedures.
- Provide school personnel, other nurses, physical education teachers, and aides or volunteers with a workshop on scoliosis screening.
- Inform parents or guardians and local physicians in writing of the planned screening. Any student should be exempted from examination upon written request of a parent or guardian.
- Select a private screening site and a date agreeable with individual school principals.
- Plan for re-screening of students found with positive indications of spinal curvature.
- Plan for student referral to private physicians, orthopedists, public clinics, or hospitals.
- Follow-up on student referrals; place physician statements in permanent files.
- Notify involved school personnel of physician's positive diagnosis of any student.

Organization

The school nurse will need to coordinate the following organizational activities closely with the principal and involved teachers:

- Students will be screened separately in an environment offering privacy. If possible, locate the screening area where students can change clothing in privacy. A room adjacent to the physical education dressing room might be most convenient.
- Determine the number of students to be screened per class, and determine whether separate days (one for boys; one for girls) or only one day will be needed. (One nurse can screen approximately 25 students per class hour.)
- If a parent contacts the school and would prefer *not* to have a child screened, be sure to privately identify the students.
- Remind students the day before scheduled screening. Some may wish to bring a change of clothing.

- Each screener will need a chair. There should also be a table nearby for use in recording information. The screeners should be five to eight feet from the subject. Place a strip of tape on the floor to mark the place the student is to stand. Good lighting will facilitate the screening.
- The student's back should be exposed as completely as practical. Girls should wear a bra or halter. Leotards and one piece swimsuits tend to camouflage the lower spine area.

Procedures and Techniques

- Student stands with *back to screener* with clothing loosened or removed to expose back. Screener checks for the following:
 - Unequal shoulder levels.
 - Symmetry of scapulae.
 - Symmetry of flanks.
 - Uneven or greater crease at one side of waist.
 - Unequal distance between body and the elbow when both arms are hanging straight down from shoulders.
- Student bends forward 90° at waist, *back to screener*, feet together, knees straight, and arms hanging in front with palms together. Observe for thoracic rib hump.
- Student *faces screener* and bends at 90° at the waist, feet together, knees straight, and arms hanging in front with palms together. Observe for lumbar hump and levels of back on both sides of the spine.
- Student *turns to side*, bends, while screener checks symmetry of both sides of the spine and looks for a smooth continuous curve of spine. Side-standing position: observe for lordosis or kyphosis.
- Record findings (see Section F-8.2).

Re-Screening

- At a separate session, re-screen all positive findings to verify original findings. Use the original control form at the re-screening. A second opinion from another school nurse is helpful.
- Since scoliosis tends to run in families, screening the siblings of children with known scoliosis is a good idea, particularly if members are eight years of age or older.
- Keep a list of students with questionable findings and arrange a second screening in four to six months.

Referral

- Students with positive findings at the re-screening should be referred to a private physician, orthopedist, public clinic, or hospital for a follow-up.
- A letter should be sent to the parent or guardian, along with a letter to the private physician, for every student with abnormal findings.
- *Send a copy* of the nurse screening form or diagrams to the private physician, orthopedist, public clinic, or hospital noting area(s) of concern.

Recording and Follow-Up

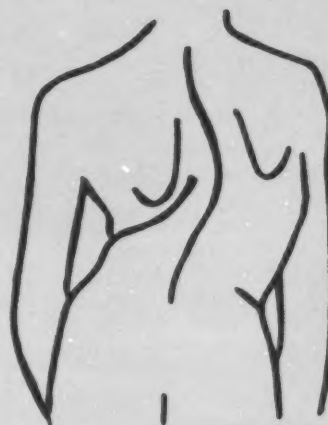
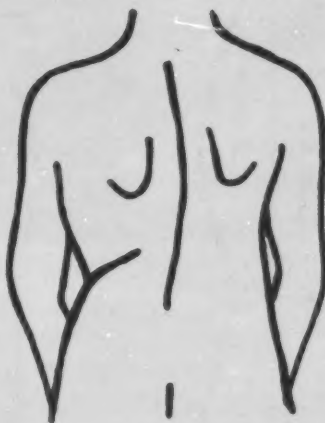
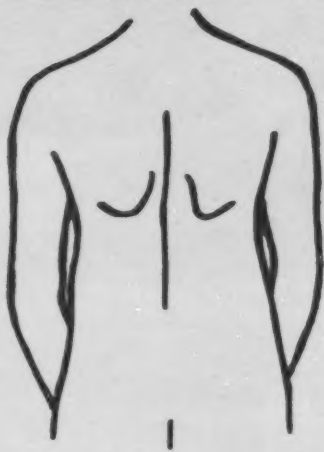
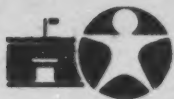
- Notation should be made on student health records of screening date and findings.
- Follow-up must be made through individual students or parents. Every effort should be made to encourage parents to follow through on referrals. Note efforts made regarding follow-up and physician diagnosis on records.

Facts About Scoliosis

- Idiopathic scoliosis: Lateral curvature of the spine with rotation of the vertebra. Cause unknown.
- Occurs eight times as often in girls as boys.
- Tends to be hereditary.
- Usually no discomfort or injury is evident, so there will be no warning.
- Can result in physical distortions if not treated.
- Can be identified without a great deal of special training.
- Signs become recognizable during preteen and teen years.
- Most often found by non-medical people due to signs such as clothing not fitting well, one shoulder or hip being higher, carrying the head in a noticeably different manner, or one leg seeming to be short, etc.
- Early identification is beneficial to the treatment program.
- Potentially can continue to get worse as long as the student continues to grow.
- Scoliosis cannot be cured but can be managed so that it does not turn into a problem, in most cases.
- X-rays are necessary to get an accurate measure of the curve at any given time.
- Bracing and exercises are the generally accepted means of treatment if the degree of curve indicates the need.
- May need surgery if it progresses.
- Can cause death in extreme cases.

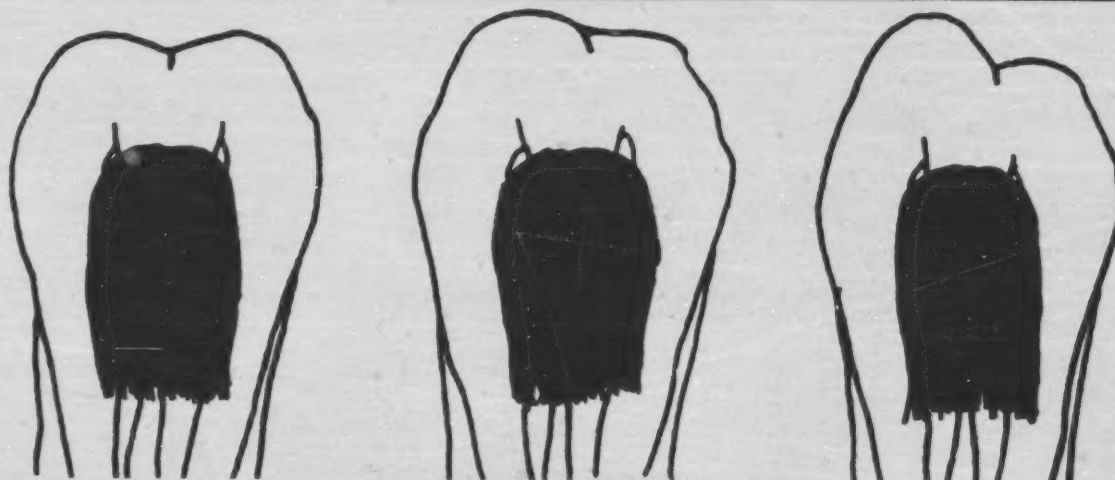
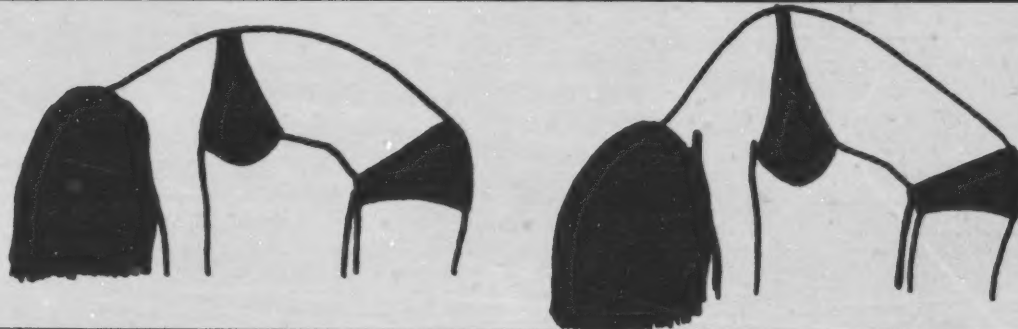
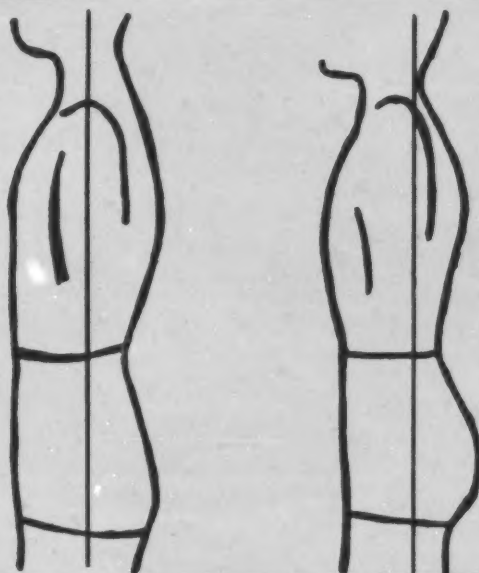
Drawings for Scoliosis Screening

Section F-8.1



Drawings for Scoliosis Screening

Section F-8.1





Scoliosis Screening Worksheet

Section F-8.2

Name _____ Age _____ Date _____ M/F _____

Address _____ School _____ Grade _____

Parent/Guardian Name _____

Examiner Name/Title _____

Back to examiner

- | | | |
|---|---------|---------|
| 1. Head and neck base off center over sacrum? | R _____ | L _____ |
| 2. Shoulder level uneven? Higher side? | R _____ | L _____ |
| 3. Shoulder blades uneven? Higher side? | R _____ | L _____ |
| 4. Waist creases uneven? Higher side? | R _____ | L _____ |
| 5. Obvious spinal curvature? | R _____ | L _____ |
| 6. Arm to body space unequal? | R _____ | L _____ |

Back toward examiner—Bent forward

- | | | |
|-----------------------------------|---------|---------|
| 7. Rib prominence on one side? | R _____ | L _____ |
| 8. Lumbar prominence on one side? | R _____ | L _____ |

Side toward examiner—View both sides—Standing and bent over

- | | | | |
|--------------------------------------|------------|------------|--------------|
| 9. Increased Roundback? | Slt. _____ | Mod. _____ | Severe _____ |
| 10. Increased Swayback? | Slt. _____ | Mod. _____ | Severe _____ |
| 11. Thoracic prominence on one side? | | R _____ | L _____ |
| 12. Lumbar prominence on one side? | | R _____ | L _____ |

Facing examiner

- | | | |
|---|---------|---------|
| 13. Shoulder level uneven? Higher side? | R _____ | L _____ |
| 14. Hip prominences unequal? Higher side? | R _____ | L _____ |
| 15. Arm to body space unequal? | R _____ | L _____ |

Facing examiner—Bent forward

- | | | |
|------------------------------------|---------|---------|
| 16. Lumbar prominence on one side? | R _____ | L _____ |
| 17. Rib prominence on one side? | R _____ | L _____ |

Is student presently under treatment for scoliosis? No _____ Yes _____

If yes, Doctor's name: _____

Send Copy with Referral Letter

(Complete Back of Page)

Scoliosis Screening Worksheet



(Back of Page: Scoliosis Screening Worksheet)

Re-check in six months: No _____ Yes _____

Referred to: School physician _____

Family physician _____

Orthopedist _____

Clinic _____

Seen by physician: No _____ Yes _____

No problem _____

Referred to specialist _____

Diagnosis _____

Treatment _____

Re-check? No _____ Yes _____ When? _____

Follow-up by school nurse, and outcome:

Student _____

Parent _____

Physician _____

Hypertension Screening

Section F-9.0

Hypertension is a significant public health problem in the United States. Prevalence rates vary by age, race, nutrition, environmental stresses, and certain physical health problems. Hypertension usually begins insidiously, seldom causing symptoms until it is well established. Hypertension may be asymptomatic.

Purpose

The purpose of a hypertension screening program in the school should be the early identification of students with consistently elevated blood pressure, with appropriate follow-up procedures. In most cases, early detection of hypertension is an aid in control leading to improved health and longer life.

Procedures and Techniques

- Educate students and staff regarding hypertension. Terminology should be kept simple for student understanding.
- Seat the child facing the screener with the forearm suitably bared, flexed, and resting on a table so the cuff will be placed at the level of the right atrium. The dial of the aneroid or mercury column should be placed so it can be read at eye level.
- Apply the appropriate size cuff with the center of the rubber bladder over the brachial artery, leaving a space of about 1 cm between the bottom of the cuff and the antecubital area.
- Locate the radial artery pulse by palpation, inflate the cuff to about 30 mm Hg above the pressure at which the radial pulse disappears. Then deflate the cuff at a rate of approximately 2 mm Hg/second. Note the level at which the radial pulse returns. Deflate cuff and wait 15 seconds.
- Locate the brachial artery pulse by palpation, place the diaphragm of the stethoscope over the artery. Rapidly inflate the cuff to a pressure approximately 30 mm Hg level at which the radial pulse was identified. Deflate the cuff gradually (2 mm/sec) until the first clear tapping sound is heard (Korotkoff sound, Phase I). Record this point as the systolic pressure. Continue to deflate the cuff while the sound becomes clearer, louder, and crisper, then suddenly changes to a low-pitched muffled one (Phase IV), then disappears (Phase V). Record Phase IV and V. Use Phase IV the point at which the sound changes, as the standard for referral (i.e., 120/80/60).
- Repeat the auscultation method to assure accuracy and allow student time to relax as the procedure becomes familiar. Verify your recording.
- Inform the student of the findings and the nature of any referral or follow-up that may be necessary. Allow student time to ask questions.

Equipment

- Mercury or aneroid sphygmomanometer. The mercury type is more reliable, accurate, and causes of error can be determined visually. It must be kept clean, glass tube free of dust, and the mercury reservoir properly filled. The aneroid manometer is less bulky but requires more frequent calibration versus a mercury manometer.
- Compression Cuff. One or more cuffs suitable to the age of students and staff are needed. The cuff must cover $\frac{3}{4}$ of the length of the upper arm, and the rubber bladder should encircle its girth.
- Stethoscope. Check stethoscope regularly to assure that earpieces are clean and that the diaphragm is intact.

Dimensions for Appropriate Size Cuff

Name	Width (cm)	Length (cm)
Newborn	2.5 - 4.0	5.0 - 10.0
Infant	6.0 - 8.0	12.0 - 13.5
Child*	9.0 - 10.0	17.0 - 22.5
Adult*	12.0 - 13.0	22.0 - 23.5
Large adult*	15.5	33.0
Adult thigh	18.0	36.0

*It is suggested these sizes be available for school use.

Normal Blood Pressure Ranges

6 years and under	78/48 - 114/80
7 - 9 years	82/52 - 120/80
10 - 12 years	90/58 - 134/84
13 - 49 years	90/60 - 140/90
50 years and older	90/60 - 160/95

Standards for Referral

- If either the systolic or diastolic reading is higher than the above levels, allow student to rest about 15 minutes and recheck. If the readings are still higher than the chart levels, recheck on another day.
- Diastolic pressure of 100 mm Hg or above should be confirmed and referred for prompt medical evaluation.
- A student with systolic or diastolic pressure above the normal range should have referral made to parent or guardian. Assistance should be offered if help is needed in obtaining medical follow-up.
- Group counseling might be effective if there are a number of students on the secondary level with blood pressure variations.

Follow-Up Procedures

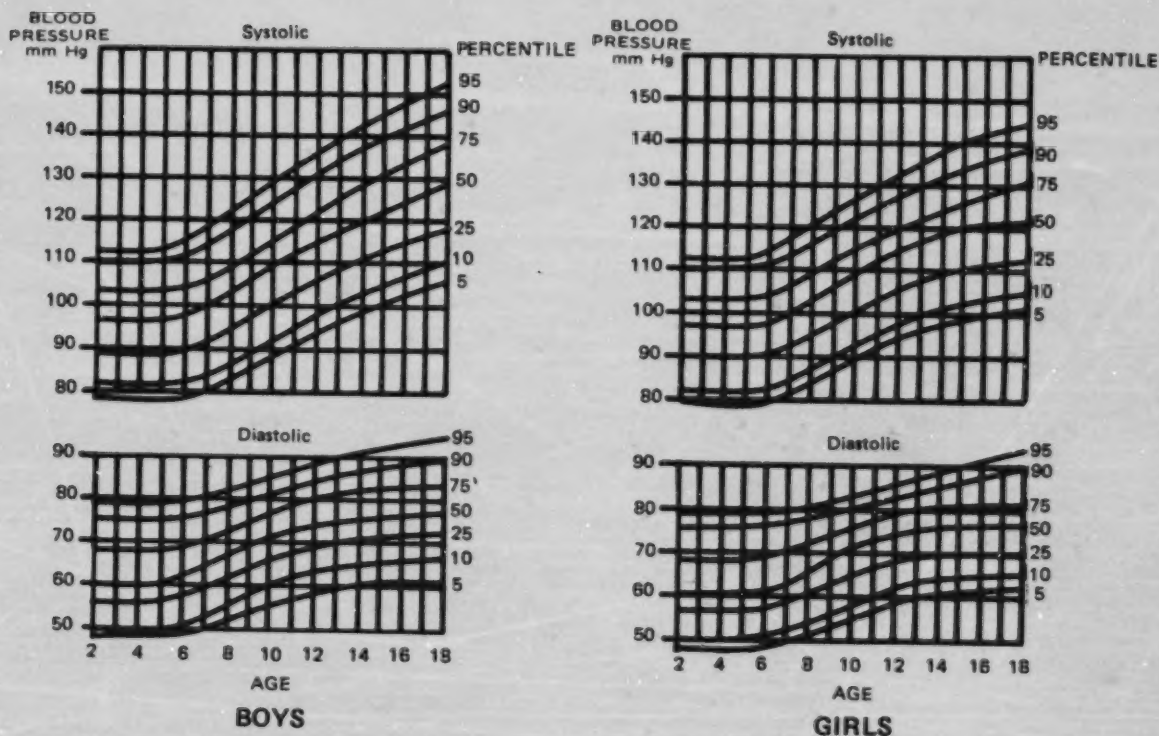
- Hypertension screening program letters should be prepared by local school districts.
- Parent or guardian of hypertensive students should be notified personally of findings. Parent education regarding hypertension should be provided.
- Continued monitoring should be provided if requested by the private physician.
- Parents, students, and staff should be emphatically made aware that school hypertension screening is not in lieu of a physician's care.
- Medication may be prescribed. The nurse should be available to administer and monitor such medication in accordance with local school board policy.
- All students with blood pressure variation should be re-screened once a year. Severity of the problem may indicate a need for more frequent checks.
- The nurse should not hesitate to discuss hypertension findings with a student's private physician.

Suggestions

- **Health Education:** Hypertension screening provides an excellent opportunity for teaching the cardiovascular system. The unit could include detailed explanation of the procedure, equipment used, normal range, significance of an elevation in blood pressure, the factors which affect blood pressure, along with importance of prevention and treatment.

Percentiles of Blood Pressure Measurement

Section F-9.1



Section G Accountability

Section G Accountability

Accountability

School health services shall be considered as part of the educational program of the school children of Texas. These services shall be provided to all children through local education agencies, in accordance with the provisions of Subchapter D of Chapter 97 of this title (relating to Principles, Standards, and Procedures for the Accreditation of School Districts), and standards established by the Texas State Department of Health and in accordance with applicable laws. The local education agency shall ensure appropriate coordination of school health services, other student services, and related instructional programs (Texas Administrative Code §85.41).

Purpose

The purpose of accountability is to document the role of health services in the delivery of health care, to evaluate the efficacy of practices, and to modify or discontinue those practices shown to have no effect on the health status of individuals.

Role

School nurses are well-qualified to assume responsibilities of planning, coordinating, implementing, and evaluating a school health program. If nurses assume this responsibility, then accountability for services provided must be accepted. Documentation and evaluation of health services provides a means toward accountability. The school nurse has:

- The expertise to detect and assess student health problems, especially at an early stage.
- The expertise and time needed to effectively follow up identified health problems, to provide health counseling to students and parents, and to motivate and help parents obtain appropriate health care for children.
- The ability to guide school administrators and teachers in modifying the school regimen and environment to meet special health needs of students.
- The knowledge to deal effectively with major emergency injuries and illnesses of students, individually or on a mass disaster basis.
- The ability to coordinate community public and private resources to help implement the total school health program.
- The knowledge to assist in the safe placement of handicapped students into the mainstream of education.
- The skill to make valid referrals to private or community resources. (Over-referrals involve unnecessary expense to parents.)
- The insight to identify health and safety hazards within the school which could endanger health or lives and reduce both the level of student ability to learn and faculty ability to teach.
- The proficiency to make an impact on Average Daily Attendance (ADA) by reducing the possibility of communicable disease and promoting high level wellness.
- The broad based health background to serve as a resource person to administrators and teachers.

School nurses may easily prepare documentation representing accountability to the school district. Documentation is basic to the registered nurse and may be readily adapted to the school setting. The school nurse, through health service, must be prepared to present the end result of planning, implementation, and evaluation to administration (see Accountability forms, Section CC).

Section H

Inservice Education

Section H	Inservice Education
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Inservice Education

Under the Texas Education Code §16.052, a school district must provide for not less than eight days of inservice training and preparation for school nurses. Not more than three of the eight days may be used as staff preparation (work) days. All professionals and paraprofessionals, except clerical aides, must participate in the inservice program. School districts may seek assistance from the regional education service centers, the Texas Education Agency, institutions of higher education, local or state health departments, or local community resources in selecting education activities which promote professional growth.

Purpose

The purpose of the guidelines is to help school districts and education service centers plan effective inservice programs consistent with state law and State Board of Education rules.

Definition

Inservice education, as defined by the State Board of Education, is "a planned program of learning opportunities afforded staff members of school districts and related agencies for purposes of improving performance in already held or assigned position."

Staff development, which is a broader term, is usually defined to include manpower planning, staffing, organizational activities, and graduate education.

A. The essential provisions of effective inservice education programs include the following:

1. Learning opportunities are provided.
2. Purposes of the inservice program are defined and related to improving performance.
3. Inservice activities address assigned jobs or positions.
4. Planned activities provide assurance of accountability for predetermined outcomes.

B. Acceptable inservice activities

The definition of inservice education permits and, in turn, restricts certain activities. Acceptable inservice activities shall include the following:

1. Any planned activity designed to produce new and/or improved performances in job assignments.
2. Activities which lead to degrees or certification, provided such credentials are not the primary purpose of the inservice.
3. Activities planned as part of the local program regardless of time, place, or persons involved.
4. The development of curriculum materials for use on the job.
5. Training activities directed toward changes in role expectations and responsibilities.
6. Evaluation activities which have as a primary objective improved performance in job assignments.
7. Communication activities designed to disseminate information among staff members and orient new staff.

C. Limitations on inservice education activities

Activities which do not fall within the scope of the definition for inservice education shall include the following:

1. Formal preparation programs directed toward new certification, advanced degrees, or specialized training for future positions rather than for improvement of performance on the current job assignment.
2. Incidental activities from which learning may be derived but for which there is no specific plan.
3. Routine activities offering no specific training opportunities for improved performance in already held or assigned positions.

Texas Education Agency, *A Guide to Better Inservice Education in Texas*, Bulletin GE2 311 01 (Austin: The Agency, 1982), p. 2.

Section AA

Resource Organizations and Literature

Section AA	Resource Organizations and Literature
	1.0 Organizations
	2.0 Executive Directors, Education Service Centers
	3.0 Local Health Departments
	4.0 Texas Department of Health Offices
	5.0 Literature

Health-related information from recognized organizations provides resources for the school nurse. The following lists of organizations, education service centers, health departments, and literature contain suggestions which may be helpful in the collection of health materials.

The school nurse has a cooperative relationship with several agencies, such as the Texas Education Agency, Texas Department of Health, and the Texas Department of Human Resources. The agencies provide information for nurse practice, supplies, films, and literature for health education. The nurse, in return, provides state agencies with data regarding immunization, communicable disease, and screenings.

Resource material used in a school health program or by a school nurse should be carefully reviewed and evaluated prior to use. It must be appropriate, current, and provide accurate information. Materials obtained from private industry or organizations must be evaluated for educational content. It should not be used in product promotion.

Organizations

Section AA-1.0

U.S. Public Health Service-Division of *Accident Prevention*:
800 North Quincy Street, Arlington, Virginia 22203.

National Clearinghouse for *Alcohol* Information:
P.O. Box 2345, Rockville, Maryland 20852.

Texas Association for the Prevention of *Alcohol* and *Drug Abuse*, Inc.:
1801 Lavaca, Austin, Texas 78701; (512) 474-1426.

National Council on *Alcoholism*:
Two East 103rd Street, New York, New York 10029.

Arthritis Foundation, The:
3400 Peachtree Road NE, Atlanta, Georgia 30326.

Texas Society for *Autistic* Citizens:
1200 Guadalupe, Austin, Texas 78701; (512) 472-1454.

March of Dimes—*Birth Defects* Foundation:
P.O. Box 2000, White Plains, New York 10602.

March of Dimes—*Birth Defects* Foundation (Texas Regional Office):
2527 Royal Lane, Suite 155, Dallas, Texas 75229; (214) 620-9779.

American Foundation for the *Blind*:
15 West 16th Street, New York, New York 10011.

State Commission for the *Blind*:
P.O. Box 12866, Austin, Texas 78711; (512) 475-1791.

National Society to Prevent *Blindness*:
79 Madison Avenue, New York, New York 10016.

Texas Society to Prevent *Blindness*:
10007 West 31st Street, Austin, Texas 78751; (512) 451-3732.
P.O. Box 13400, Houston, Texas 77019; (713) 526-2559.

American *Cancer* Society:
777 Third Avenue, New York, New York 10017.

American *Cancer* Society—Texas Division:
P.O. Box 9863, Austin, Texas 78766; (512) 345-4560.

United *Cerebral Palsy* Association, Inc.:
66 East 34th Street, New York, New York 10016.

United *Cerebral Palsy* Association of Texas, Inc.:
7801 North Lamar, Austin, Texas 78757; (512) 458-8161.

National Society for *Crippled* Children and Adults, Inc.:
2023 West Ogden Avenue, Chicago, Illinois 60612.

Cystic Fibrosis Foundation:
6000 Executive Blvd., Suite 309, Rockville, Maryland 20852.

Organizations

Section AA-1.0

National Dairy Council:

6300 North River Road, Rosemont, Illinois 60018.

National Association for the Deaf:

814 Thayer Avenue, Silver Spring, Maryland 20910.

National Association for the Deaf/Blind:

2703 Forest Oak Circle, Norman, Oklahoma 73071.

American Dental Association:

211 East Chicago Avenue, Chicago, Illinois 60611.

Texas Dental Association:

1946 S. Interregional Hwy., Austin, Texas 78704; (512) 443-3675.

Texas Department of Health—Bureau of Dental Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7323.

American Diabetes Association:

Two Park Avenue, New York, New York 10016.

American Diabetes Association—North Texas Affiliate:

5415 Maple Avenue, Dallas, Texas 75235; (214) 638-5400.

American Diabetes Association—South Texas Affiliate:

P.O. Box 14926, Austin, Texas 78761; (512) 454-7614.

American Dietetic Association:

430 North Michigan Avenue, Chicago, Illinois 60611.

Texas Dietetic Association:

900 Old Koenig Lane, Austin, Texas 78751; (512) 458-6728.

National Clearinghouse for Drug Abuse Information:

P.O. Box 2305, Rockville, Maryland 20852.

Texas Education Agency:

201 East 11th Street, Austin, Texas 78701; (512) 834-4000.

Epilepsy Foundation of America:

1828 L Street NW, Suite 406, Washington, DC 20036.

National Health Information Clearinghouse, NHIC, (*Health Calendar*):

P.O. Box 1133, Washington, DC 20013; 1-800-336-4797.

Texas Department of Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7111.

Texas Education Agency, TEA, *Health Services Consultant*:

201 East 11th Street, Austin, Texas 78701; (512) 834-4081.

U.S. Department of Health and Human Services—Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine:

Hubert H. Humphrey Building, 200 Independent Avenue SW, Washington, DC 20201.

Organizations

Section AA-1.0

American Heart Association:

7329 Greenville Avenue, Dallas, Texas 75231; (214) 750-5300.

American Heart Association—Texas Affiliate, Inc.:

P.O. Box 15186, Austin, Texas 78761; (512) 836-7220.

Texas Department of Human Resources:

1708 East Anderson Lane, Austin, Texas 78752; (512) 441-3355.

American Humane Association—Children's Division:

P.O. Box 1266, Denver, Colorado 80201.

Kidney Foundation:

Two Park Avenue, New York, New York 10016.

Kidney Foundation of Texas:

13500 Midway, Dallas, Texas 75234; (214) 934-8057.

Texas Association for Children with Learning Disabilities:

1011 West 31st Street, Austin, Texas 78756; (512) 458-8234.

Leukemia Society of America:

800 Second Avenue, New York, New York 10017.

118 Broadway, San Antonio, Texas 78205; (512) 225-4404.

Texas Department of Health, Life Program, Bureau of Chronic Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7534.

American Lung Association:

1704 Broadway, New York, New York 10019.

American Lung Association of Texas:

7701 North Lamar, Suite 104, Austin, Texas 78752; (512) 458-2206.

Texas Department of Health, Bureau of Maternal and Child Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7770.

American Medical Association:

535 North Dearborn Street, Chicago, Illinois 60610.

Texas Medical Association:

1801 North Lamar, Austin, Texas 78756; (512) 477-6704.

Texas Department of Mental Health-Mental Retardation:

P.O. Box 12668, Austin, Texas 78711; (512) 454-3761.

National Multiple Sclerosis Society—Public Relations Department:

257 Park Avenue South, New York, New York 10017.

Muscular Dystrophy Association, Inc.:

810 Seventh Avenue, New York, New York 10019.

Muscular Dystrophy Association:

7718 Wood Hollow, Austin, Texas 78731; (512) 345-3800.

Organizations

Section AA-1.0

American Nurses Association:

2420 Pershing Road, Kansas City, Kansas 64108.

1030 15th Street NW, Washington, DC 20005.

Texas Nurses Association:

314 Highland Mall Blvd., Suite 504, Austin, Texas 78752; (512) 452-0645.

Texas State Board of Nurse Examiners—Registered Professional Nurses:

1300 East Anderson Lane, Austin, Texas 78752; (512) 835-4880.

National League for Nursing:

28 Westfall Road, Rochester, New York 14620.

Society for Nutrition Education:

1736 Franklin Street, Oakland, California 94612.

Texas Association of Optometrists:

1220 Colorado, Austin, Texas 78701; (512) 478-3753.

Planned Parenthood Federation of America:

810 Seventh Street, New York, New York 10019.

Planned Parenthood Education Center:

1703 East Seventh Street, Austin, Texas 78702; (512) 472-0868.

Parents Anonymous:

24-hour toll free hotline; 1-800-421-0353.

American Academy of Pediatrics:

P.O. Box 1034, Evanston, Illinois 60204.

American Public Health Association:

1015 18th Street NW, Washington, DC 20036.

Texas Public Health Association:

8140 Burnet Road, Austin, Texas 78756; (512) 451-0846.

American National Red Cross:

17th and D Streets NW, Washington, DC 20006.

2300 McKinney, Dallas, Texas 75201; (214) 741-4421.

P.O. Box 397, Houston, Texas 77001; (713) 424-5050.

Texas Rehabilitation Commission:

118 East Riverside Drive, Austin, Texas 78704; (512) 447-0163.

Texas Association for Retarded Citizens:

833 Houston Street, Austin, Texas 78701; (512) 454-6694.

National Runaway Switchboard:

24-hour toll free hotline; 1-800-621-4000.

National Safety Council—Director of Public Information:

425 North Michigan Avenue, Chicago, Illinois 60611.

Organizations

Section AA-1.0

American School Health Association:

P.O. Box 708, Kent, Ohio 44230.

Texas School Health Association, c/o American Heart Association:

Attention: Betty Tevis, 7320 Greenville, Dallas, Texas 75231; (214) 748-7212.

Texas State Teachers Association—School Health Section for Nurses:

316 West 12th Street, Austin, Texas 78701; 1-800-252-9673 or (512) 476-5355.

National Association of School Nurses:

New York Statler Hotel, Suite 104, New York, New York 10001.

National Educational Association—Department of School Nurses:

1201 16th Street NW, Washington, DC 20036.

National Scoliosis Foundation, Inc.:

48 Stone Road, Belmont, Maine 02178.

National Clearinghouse on Smoking and Health Center for Disease Control:

Atlanta, Georgia 30333.

Texas Speech and Hearing Association:

1209 West 34th Street, Austin, Texas 78756; (512) 452-8278.

Texas Department of Health, Speech and Language Screening:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7420.

American Speech, Language, and Hearing Association:

10801 Rockville Pike, Rockville, Maryland 20852.

American Association of Suicidology (AAS):

Central Office: 2459 South Ash, Denver, Colorado 80222.

Tattle Tooth Program, Bureau of Dental Health, Texas Department of Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7111.

Toughlove:

Community Services Foundation, Box 70, Sellersville, Pennsylvania 18960.

2208 Brookhill Drive, Austin, Texas 78745; (512) 442-1198.

Texas Department of Health, Vision, Screening Programs:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7420.

Texas Board of Vocational Nurse Examiners:

1300 East Anderson Lane, Austin, Texas 78752; (512) 835-2071.

Executive Directors, Education Service Centers

Section AA-2.0

REGION I

Mr. Lauro Guerra
Region I Education Service Center
1900 West Schunior
Edinburg, Texas 78539
Telephone: (512) 383-5611

REGION II

Mr. Gerald Cook
Region II Education Service Center
209 N. Water Street
Corpus Christi, Texas 78401
Telephone: (512) 883-9288

REGION III

Dr. Dennis Grizzle
Region III Education Service Center
1905 Leary Lane
Victoria, Texas 77901
Telephone: (512) 573-0731

REGION IV

Dr. Tom Pate, Jr.
Region IV Education Service Center
P. O. Box 863
Houston, Texas 77001
Location: 7200 West Tidwell
Telephone: (713) 462-7708

REGION V

Dr. Fred Maddell
Region V Education Service Center
2295 Delaware Street
Beaumont, Texas 77703
Telephone: (409) 835-5212

REGION VI

Mr. Max W. Schlotter
Region VI Education Service Center
3332 Montgomery Road
Huntsville, Texas 77340
Telephone: (409) 295-9161

REGION VII

Mr. Donald J. Peters
Region VII Education Service Center
P. O. Drawer 1622
Kilgore, Texas 75662
Location: 818 East Main Street
Telephone: (214) 984-3071

REGION VIII

Mr. Scott Ferguson
Region VIII Education Service Center
100 North Riddle Street
Mt. Pleasant, Texas 75455
Telephone: (214) 572-6676

REGION IX

Dr. Jim O. Rogers
Region IX Education Service Center
Wichita Falls, Texas 76305
Location: 301 Loop 11
Telephone: (817) 322-6928

REGION X

Mr. Hayden W. Goodgion
Region X Education Service Center
P. O. Box 1300
Richardson, Texas 75080
Location: 400 E. Spring Valley Road
Telephone: (214) 231-6301

REGION XI

Mr. R. P. Campbell, Jr.
Region XI Education Service Center
3001 North Freeway
Fort Worth, Texas 76106
Telephone: (817) 625-5311

REGION XII

Mr. Jack Ross (Acting Director)
Region XII Education Service Center
P. O. Box 1249
Waco, Texas 76703
Location: 401 Franklin Avenue
Telephone: (817) 756-7494

REGION XIII

Dr. Joe Parks
Region XIII Education Service Center
7703 North Lamar Blvd.
Austin, Texas 78752
Telephone: (512) 458-9131

REGION XIV

Dr. Thomas Lawrence
Region XIV Education Service Center
P. O. Box 3258
Abilene, Texas 79604
Location: 1850 State Highway 351
Telephone: (915) 676-8201

REGION XV

Mr. Clyde Warren
Region XV Education Service Center
P. O. Box 5199
San Angelo, Texas 76902
Location: 612 South Irene Street
Telephone: (915) 658-6571

REGION XVI

Dr. Kenneth Laycock
Region XVI Education Service Center
P. O. Box 30600
Amarillo, Texas 79102
Location: 1601 South Cleveland
Telephone: (806) 376-5521

REGION XVII

Dr. Delwin Webb
Region XVII Education Service Center
4000 22nd Place
Lubbock, Texas 79410
Telephone: (806) 792-4000

REGION XVIII

Dr. J. W. Donaldson
Region XVIII Education Service Center
P. O. Box 6020
Midland, Texas 79701
Location: LaForce Boulevard
Telephone: (915) 563-2380

REGION XIX

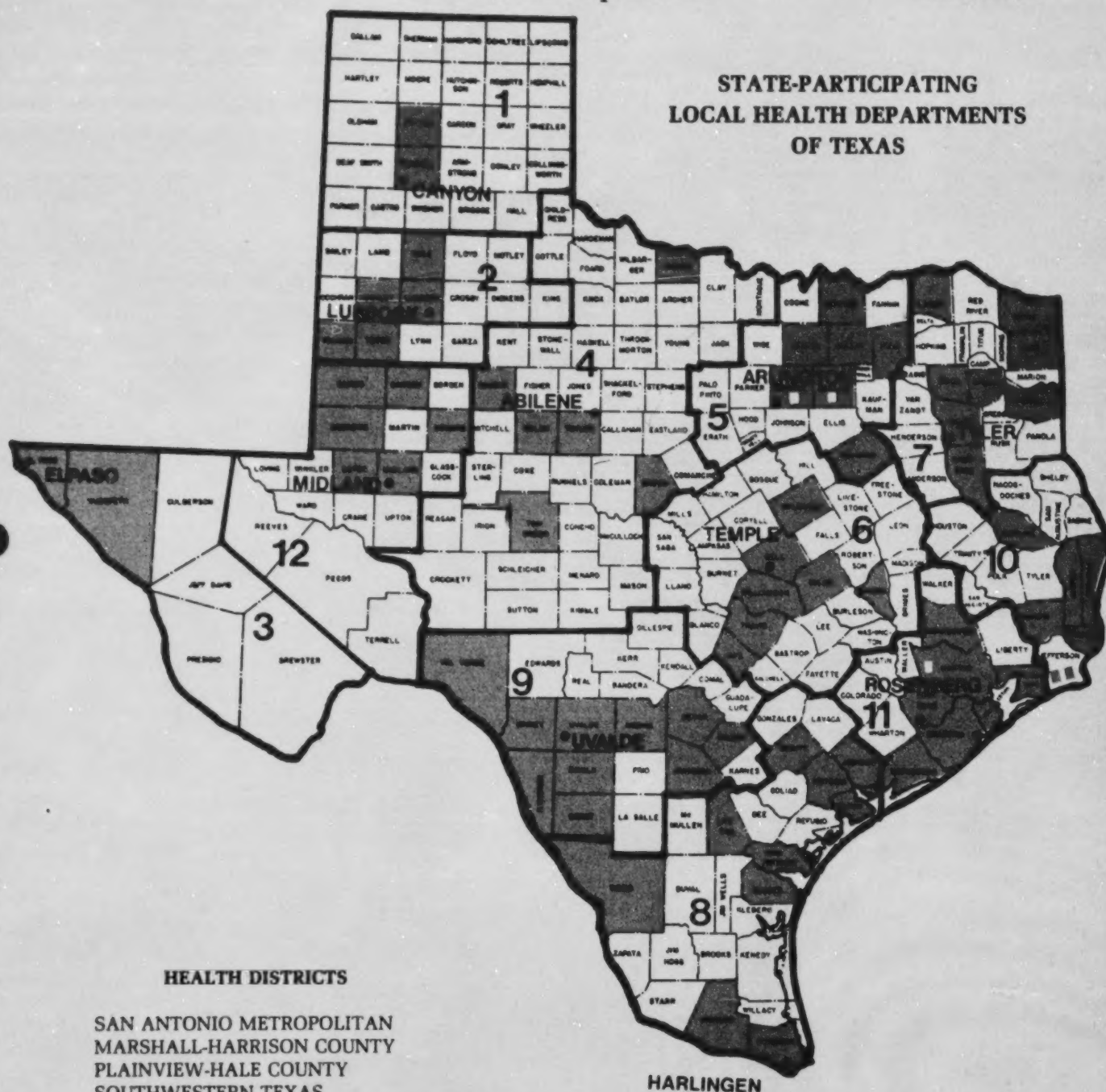
Dr. John E. Uxer
Region XIX Education Service Center
P. O. Box 10716
El Paso, Texas 79997
Location: 6611 Boeing Drive
Telephone: (915) 779-3737

REGION XX

Dr. Dwain Estes
Region XX Education Service Center
1314 Hines Avenue
San Antonio, Texas 78208
Telephone: (512) 271-7611

Local Health Departments

Section AA-3.0



- CITY-COUNTY DEPARTMENTS
- CITY DEPARTMENTS
- REGIONAL HEADQUARTERS

Texas Department of Health Offices

Section AA-4.0

Texas Department of Health

December 1982
(512/458-7111)

- COMMISSIONER OF HEALTH
Office of General Counsel
Office of the BOARD OF HEALTH
DEPUTY COMMISSIONER FOR PROFESSIONAL SERVICES
Public Health Promotion Division
DEPUTY COMMISSIONER FOR MANAGEMENT & ADMINISTRATION
Internal Audit
Bureau of Personnel Management
ASSOCIATE COMMISSIONER FOR COMMUNITY & RURAL HEALTH
Bureau of Community Health Services
Local Health Services Division
Hospital Care Division
San Antonio Chest Hospital
Harrington Chest Hospital
Public Health Nursing Division
Regional Programs
ASSOCIATE COMMISSIONER FOR PERSONAL HEALTH SERVICES
Bureau of Dental Health
Bureau of Crippled Children's Services
Crippled Children's Services Program
Adult Assistance Program
SBI-Disabled Children's Program
Early Childhood Intervention Program
Bureau of Maternal and Child Health
Child Health Division
Maternal Health and Family Planning Division
Bureau of Chronic Disease
Adult Health Services Program
Kidney Health Care Program
Bureau of Emergency Management
Emergency Medical Services Division
Medical Standards on Motor Vehicle Operations Division
Disaster Response Program
ASSOCIATE COMMISSIONER FOR PREVENTABLE DISEASES
Bureau of Communicable Disease Services
Immunization Division
Infectious Disease Control Division
Tuberculosis Services Division
Bureau of Epidemiology
Investigation and Studies Division
Surveillance and Statistics Division
Cancer Registry Program
Bureau of Laboratories
Chemical Services Division
Microbiological Services Division
Support Services Division
Bureau of Veterinary Public Health
Zoonosis Control Division
Cooperative Meat Inspection Division
ASSOCIATE COMMISSIONER FOR SPECIAL HEALTH SERVICES
Bureau of Long Term Care
Quality Standards Division
Professional Services Division
Bureau of State Health Planning & Resource Development
Bureau of Vital Statistics
Vital Records Division
Statistical Services Division
Bureau of Licensing and Certification
Hospital and Professional Licensure Division
Medicare Certification Division
Pharmacy Division
ASSOCIATE COMMISSIONER FOR ENVIRONMENTAL AND CONSUMER HEALTH PROTECTION
Bureau of Radiation Control
Environmental Programs Division
Licensing, Registration and Standards Division
Compliance and Inspection Division
Bureau of Consumer Health Protection
Food and Drugs Division
Milk and Dairy Products Division
Shellfish Sanitation Control Division
Bureau of Solid Waste Management
Permits Division
Surveillance and Enforcement Division
Hazardous Waste and Resource Recovery Programs Management Division
Bureau of Environmental Health
Occupational Health Program
Occupational Safety Division
General Sanitation Division
Water Hygiene Division
ASSOCIATE COMMISSIONER FOR SUPPORT SERVICES
Office of Grants and Contract Development
Materials Acquisition and Management Division
Bureau of Automated Data Services
Bureau of Central Administrative Services
Radiographics & Educational Services
Budget and Planning Division
Fiscal Division
General Services Division
- Robert Bernstein, M.D., F.A.C.P. (7375)
Hal L. Nelson, J.D. (7238)
Gary A. Fuchs, B.A. (7484)
Robert A. MacLean, M.D. (7378)
Charles T. Kozel, M.P.H. (7408)
Hermas L. Miller, B.S.A. (7488)
Donald O. Cox, B.S.A. (7364)
Glenn W. Rust, B.S.A. (7301)
C. C. Savas, M.D. (7770)
- Charles L. Hill, M.S. (7700)
Andre J. Ognibene, M.D. (512/534-8857)
Robert Narmas, M.D. (Acting) (512/423-3420)
Joy M. Pappas, R.N. (7770)
Robert A. Mauck, B.S. (7770)
Cliff Price, M.D. (7321)
Carlos Lozano, D.D.S., M.P.H. (7320)
Punam Myer, M.D., M.P.H. (7341)
Joe B. Horsley (7241)
Bob R. Barnes (7241)
Helen Burt (7445)
Pam Farley (7445)
Walter P. Peter, Jr., M.D. (7700)
Gilbert D. Levine, M.D. (7700)
Walter P. Peter, Jr., M.D. (Acting) (7700)
Willard M. Drake, Jr., M.D. (Acting) (7534)
Bill Nichols, B.S. (7534)
Manuel Zapata, B.A. (7338)
Charles H. Gregory, M.D. (7551)
Eugene Weatherall, B.S. (7401)
James Shuffield, B.A. (7401)
Bert Crowson, M.S. (7415)
Jerome H. Greenberg, M.D. (7304)
C. E. Alexander, M.D., Dr. P.H. (7488)
Evel A. Smith, B.A. (7284)
Joe D. Pair (7225)
Robert E. Monroe, B.S. (7447)
Charles R. Webb, Jr., M.D. (7207)
Charles R. Webb, Jr., M.D. (Acting) (7207)
Charles R. Webb, Jr., M.D. (Acting) (7207)
Amelia Mancheri (7206)
Charles E. Sweet, M.P.H., Dr. P.H. (7318)
Bradford L. Thernell, Jr., Ph.D. (7430)
David L. Maserang, Ph.D. (7581)
Michael J. McCauley, Ph.D. (7570)
F. V. McCasland, D.V.M., M.P.H. (7221)
- James R. Weedon, D.V.M., M.P.H. (7221)
Lynn S. McGuire, R.N. (7298)
Cesar M. Elizondo, M.D. (7708)
Jerry W. Bryant, M.S. (7811)
Dayland Parsons, B.S.A. (7710)
Mike Ezell, M.Ed. (7281)
W. D. Carroll, B.S.A., M.P.H. (7882)
J. L. Howie, B.A. (7288)
William E. Barrington, Jr., B.S.A., M.P.H. (7288)
Maurice B. Shaw, B.S.A., M.S. (7538)
Walter L. Dick, B.S.A. (7531)
Juanita Carroll, Ed.D. (7245)
James O. Allan, R.Ph. (7888)
- David M. Cochran, M.S., P.E. (7541)
David K. Lacher, M.S. (512/836-7000)
Joseph F. Thiel, B.S. (512/836-7000)
Edgar D. Bailey, M.S., P.E. (512/836-7000)
Richard A. Ratliff, M.S., P.E. (512/836-7000)
Neil B. Travis, B.S., R.S. (Acting) (7537)
Robert L. Hanna, B.S., R.Ph. (7548)
Kimon C. Smith, B.S., R.S. (7281)
Neil B. Travis, B.S., R.S. (7510)
Jack C. Carmichael, M.S., P.E. (7271)
Hector H. Mandelata, B.S.M.E., P.E. (7271)
Llewellyn B. Griffith, Jr., M.S., P.E. (7271)
- Wiley W. Osborne, M.S., P.E. (7271)
C. K. Foster, B.S.C.E., P.E. (7548)
Jerry F. Leubertele, M.S., P.E. (7284)
Walter G. Martin, B.S.M.E., P.E. (7287)
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Section BB

Legislation Impacting a School Health Program

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| Section BB | Legislation Impacting a School Health Program <ul style="list-style-type: none">1.0 Architectural Barriers (Handicapped or Disabled)2.0 Audiometric Use and Registration3.0 Breakfast Programs4.0 Child Abuse, Report of5.0 Communicable Diseases, Rules and Regulations for the Control of6.0 Courses of Study7.0 Employment Contracts, Teachers' (Nurses')8.0 Eye Devices, Protective, in Public Schools9.0 Fire Escapes10.0 Foundation School Program Fund, Requirements for District Participation in the11.0 Handicapped Children, Coordination of Services to12.0 Health Program, Coordinated (Cooperation in Establishment of Program)13.0 Health and Safety14.0 Health Services15.0 Immunization Requirements in Texas, Elementary and Secondary Schools and Institutions of Higher Education16.0 Immunization; Requirements; Exceptions17.0 Liability, Duties of Professional Employees18.0 Medical Treatment, Consent to19.0 Medication, Administering of by School District Employees; Immunity From Liability20.0 Nurse Practice Act (Registered Nurse)21.0 Open Records Act22.0 Pediculosis, Control and Eradication of in Minors23.0 Physical Evaluations of School Children, Pilot Programs for24.0 Principals, Duties of Public School25.0 Quarantine and Disinfection26.0 Rights, Privileges, and Obligations of 18-Year-Olds27.0 Sanitation and Health Protection28.0 Special Education Program, Comprehensive for Handicapped Children29.0 Student Services30.0 Tuberculosis, Examining Public School Personnel31.0 Tuberculosis, Prevention, Eradication, and Control of32.0 Vision Screening Act of 1979, Children's33.0 Visually Handicapped, Education for the34.0 Vocational Nurse Act35.0 Medical Practice Act of Texas36.0 Texas Pharmacy Act |
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Architectural Barriers (Handicapped or Disabled)

Section BB-1.0

Tex. Rev. Civ. Stat. Ann., Art 601b §§7.01 and 7.04 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§7.01. Policy

The provisions of this article are to further the policy of the State of Texas to encourage and promote the rehabilitation of handicapped or disabled citizens and to eliminate, insofar as possible, unnecessary barriers encountered by aged, handicapped, or disabled persons, whose ability to engage in gainful occupations or to achieve maximum personal independence is needlessly restricted when such persons cannot readily use public buildings.

§7.04. Definitions

For the purpose of this article the following terms have the meanings as herein set forth:

(1) "Nonambulatory disabilities" means impairments that, regardless of cause or manifestation, for all practical purposes, confine individuals to wheelchairs.

(2) "Semiambulatory disabilities" means impairments that cause individuals to walk with difficulty or insecurity.

Individuals using braces or crutches, amputees, arthritics, spastics, and those with pulmonary and cardiac ills may be semiambulatory. The listing here made is illustrative and shall not be construed as being exhaustive.

(3) "Sight disabilities" means total blindness or impairments affecting sight to the extent that the individual functioning in public areas is insecure or exposed to danger.

(4) "Hearing disabilities" means deafness or hearing handicaps that might make an individual insecure in a public area because he is unable to communicate or hear warning signals.

(5) "Disabilities of coordination" means faulty coordination or palsy from brain, spinal, or peripheral nerve injury.

(6) "Aging" means those manifestations of the aging processes that significantly reduce mobility, flexibility, coordination, and perceptiveness but are not accounted for in the aforementioned categories.

Audiometric Use and Registration

Section BB-2.0

Tex. Rev. Civ. Stat. Ann., Art. 4590F, §10b (Vernon Supp. 1982). 25 Tex. Admin. Code §289.3 (McGraw-Hill, 1981).

The Texas State Radiation Control Agency may institute training programs for the purpose of qualifying personnel to carry out the provisions of this Act, and may make said personnel available for participation in any program or programs of the Federal Government, other states or interstate agencies in furtherance of the purposes of this Act.

§130.1. Purpose

The purpose of this part is to provide for the registration of possession and use of audiometers, audiometric testing devices, and audiometric calibration equipment.

§130.2. Scope

All audiometers, audiometric testing devices, or audiometric calibration equipment unless exempt from this part by paragraphs 130.3 or 130.4 shall be registered with the Agency (Texas Department of Health) in accordance

with the requirements of paragraph 130.5. Each user of an audiometer or audiometric testing device shall be registered with, trained by, or have training approved by, and shall file reports as directed by the Agency. Persons calibrating audiometers, audiometric testing devices, or audiometric calibration equipment shall be registered with, have training approved by, and shall file reports as directed by the Agency.

§130.5. Registration

(a) Each person having possession of, or using audiometers, audiometric testing devices, or audiometric calibration equipment not exempted by these regulations, shall register such equipment within thirty (30) days following the commencement of an activity involving the operation of an audiometer, audiometric testing device, or audiometric calibration equipment.

Breakfast Programs

Section BB-3.0

Tex. Educ. Code Ann., §21.914 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.914.

If at least 10 percent of the students enrolled in one or more schools in a school district are eligible for free or reduced-price breakfasts under the national school breakfast program provided for by the Child Nutrition Act

of 1966 (42 U.S.C. Subsection 1773), the governing board of the district shall participate in the program and make the benefits of the program available to all eligible students in said schools.

Report of Child Abuse

Section BB-4.0

Tex. Fam. Code Ann., §§34.01, 34.03, 34.04, 34.06 (Vernon 1975). Tex. Fam. Code Ann. §§34.011, 34.02, 34.05, 34.07, 34.08 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§34.01. Persons Required to Report

Any person having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect shall report in accordance with Section 34.02 of this code.

§34.011. Form

The Texas Department of Human Resources shall promulgate a form and cause a sample to be distributed for the reporting of suspected occurrences of child abuse as required by Section 34.01 of this code. Copies of the form shall be distributed to all licensed hospitals in this state to be available for use without charge by hospital employees, physicians, patients, and other persons. The form shall include a statement that child abuse reports are confidential and that information contained in the reports, including the name of the person making the report, may be used only for the purposes consistent with the investigation of child abuse. The form shall give the address of the Texas Department of Human Resources. Hospital employees, physicians, patients, and other persons must complete the form and return it to the Texas Department of Human Resources.

§34.02. Contents of Report: to Whom Made

(a) Nonaccusatory reports reflecting the reporter's belief that a child has been or will be abused or neglected, or has died of abuse or neglect, has violated the compulsory school attendance laws on three or more occasions, or has, on three or more occasions, been voluntarily absent from his home without the consent of his parent or guardian for a substantial length of time or without the intent to return shall be made to:

- (1) the State Department of Public Welfare;
- (2) the agency designated by the court to be responsible for the protection of children; or
- (3) any local or state law enforcement agency.

(b) All reports must contain the name and address of the child, the name and address of the person responsible for the care of the child, if available, and any other pertinent information.

(c) All reports received by any local or state law enforcement agency shall be referred to the State Department of Public Welfare or to the agency designated by the court to be responsible for the protection of children.

(d) An oral report shall be made immediately on learning of the abuse or neglect as prescribed in Subsection (a) of this section, and a written report shall be made within five days to the same agency or department. Anonymous reports, while not encouraged, will be received and acted on in the same manner as acknowledged reports.

§34.03. Immunities

Any person reporting pursuant to this chapter is immune from liability, civil or criminal, that might otherwise be incurred or imposed. Immunity extends to participation in any judicial proceeding resulting from the report. Persons reporting in bad faith or malice are not protected by this section.

§34.04. Privileged Communications

In any proceeding regarding the abuse or neglect of a child or the cause of any abuse or neglect, evidence may not be excluded on the ground of privileged communication except in the case of communications between attorney and client.

§34.05. Investigation and Report of Receiving Agency

(a) The State Department of Public Welfare or the agency designated by the court to be responsible for the protection of children shall make a thorough investigation

promptly after receiving either the oral or written report. The primary purpose of the investigation shall be the protection of the child.

(b) In the investigation the department or agency shall determine:

- (1) the nature, extent, and cause of the abuse or neglect;
- (2) the identity of the person responsible for the abuse or neglect;
- (3) the names and conditions of the other children in the home;
- (4) an evaluation of the parents or persons responsible for the care of the child;
- (5) the adequacy of the home environment;
- (6) the relationship of the child to the parents or persons responsible for the care of the child;
- (7) all other pertinent data.

(c) The investigation shall include a visit to the child's home, a physical examination of all the children in that home, and an interview with the subject child. The investigation may include a psychological or psychiatric examination of all the children in that home. If admission to the home, school, or any place where the child may be, or permission of the parents or persons responsible for the child's care for the physical examinations cannot be obtained, then the juvenile court, or the district court, upon cause shown, shall order the parents or the persons responsible for the care of the children, or the person in charge of any place where the child may be, to allow entrance for the interview, the physical examination, and the investigation. If the parents or person responsible for the child's care does not consent to a psychological or psychiatric examination of the child that is requested by the department or agency, the juvenile court or district court, upon cause shown, shall order the examination to be made at the times and places designated by the court. A parent or person responsible for the child's care is entitled to notice and a hearing when the department or agency seeks a court order to allow a psychological or psychiatric examination.

(d) If, before the investigation is complete, the opinion of the investigators is that immediate removal is necessary to protect the child from further abuse or neglect, the investigators shall file a petition pursuant to Chapter

17 of this code¹ for temporary care and protection of the child.

(e) The agency designated by the court to be responsible for the protection of children or the department shall make a complete written report of the investigation. The report, together with its recommendations, shall be submitted to the juvenile court or the district court, the district attorney, and the appropriate law enforcement agency if sufficient grounds for the institution of a suit affecting the parent-child relationship are found.

(f) On the receipt of the report and recommendation required by Subsection (e) of this section, the court may direct the investigator to file a petition seeking appropriate relief under Subtitle A of this title.²

¹Section 17.01 et seq.

²Section 11.01 et seq.

§34.06. Central Registry

The State Department of Public Welfare shall establish and maintain in Austin, Texas, a central registry of reported cases of child abuse or neglect. The department may adopt rules and regulations as are necessary in carrying out the provisions of this section. The rules shall provide for cooperation with local child service agencies, including hospitals, clinics, and schools, and cooperation with other states in exchanging reports to effect a national registration system.

§34.07. Failure to Report; Penalty

(a) A person commits an offense if the person has cause to believe that a child's physical or mental health or welfare has been or may be further adversely affected by abuse or neglect and knowingly fails to report in accordance with Section 34.02 of this code.

(b) An offense under this section is a Class B misdemeanor.

§34.08. Confidentiality

The reports, records, and working papers used or developed in an investigation made under this chapter are confidential and may be disclosed only for purposes consistent with the purposes of this code under regulations adopted by the investigating agency.

Rules and Regulations for the Control of Communicable Diseases Section BB-5.0

25 Tex. Admin. Code §§97.1-97.9 (McGraw-Hill, 1981).

§97.1. Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Carrier—A person who harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source or reservoir of infection for man.

Case—As distinct from a carrier, the term "case" is used to mean a person in whose tissues the etiological agent of a communicable disease is lodged and which usually produces signs or symptoms of disease. Evidence of the presence of a communicable disease may be also revealed by routine laboratory findings.

Communicable disease—An illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a well person from an infected person or animal, or through the agency of an intermediate animal host, vector, or inanimate object in the environment.

Contact—A person or animal that has been in such association with an infected person or a contaminated environment so as to have had opportunity to acquire the infection.

Disinfection—Killing of pathogenic agents outside the body by chemical or physical means directly applied.

Epidemic or outbreak—An epidemic or outbreak is here defined as the occurrence in a community or region of a group of illnesses of similar nature, clearly in excess of normal expectancy, and derived from a common or a propagated source.

Infectious disease—A disease of a man or animal resulting from the entry and development or multiplication of a particular pathogen in the body of man or animal.

Isolation—The separation for the period of communicability of infected individuals from other individuals, in such places and under such conditions as will prevent the direct or indirect transmission of the infectious agent from infected individuals to other individuals who are susceptible or who may spread the agent to others.

Local health authority—For the purpose of these sections the term "local health authority" shall be held to designate the city or county health officer, a director of an organized health department or a local board of health, or the director of a Texas Public Health Region, within their respective jurisdictions.

Modified quarantine—As authorized by the commissioner of health, measures established by the local health authority which are carried out as necessary to protect the public health.

Quarantine—The limitation of freedom of movement of such well persons or domestic animals as have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period.

Report of a disease—By report of a disease or outbreak of disease cases is meant the notification to the local health authority of each and all disease cases including all information required by the procedures established by the commissioner of health.

Reportable disease—A "reportable disease" shall mean any disease or condition for which an official report is required.

See §97.5(b) of this title (relating to Prevention of the Spread of Disease from a case). Any unusual group ex-

pression of illness which may be of public concern is reportable and shall be reported to the local health authority or the Texas Department of Health by the most expeditious means.

§97.2. Diseases Requiring Exclusion from School

(a) Children suffering from any reportable disease shall be barred from school attendance.

(b) In addition to reportable diseases, children suffering from scabies, impetigo contagiosa, ringworm, trachoma, common cold, infectious forms of conjunctivitis, and pediculosis also may be barred from school attendance.

(c) All children excluded from school for reason of communicable disease may be readmitted to school by one of the following methods:

(1) On the certificate of the attending physician attesting to their recovery and non-infectiousness.

(2) A permit for readmission to school issued by a local health authority. See §97.1 of this title (relating to Definitions).

(3) After a period of time corresponding to the communicability of the disease as established by the commissioner of health. The method of readmission to school is to be determined by the local health authority in each particular area.

§97.3. Hospitals to Report Communicable Diseases

(a) The chief administrative officer of each civilian hospital, dispensary, or clinic in the State is requested to appoint an individual from the full time staff, hereinafter referred to as the "reporting officer," who shall be responsible for reporting to the local health authority cases or suspect cases of communicable diseases admitted to the facility. The United States military and other federally operated hospitals and clinics are requested to do likewise.

(b) Hospital and clinic reports shall be made to the local health authority at weekly intervals.

(c) Reporting officers shall telephone immediately reports of cases or suspect cases as delineated on the official list of reportable diseases. See §97.5(b) of this title (relating to Prevention of the Spread of Disease for a Case).

(d) Reports of communicable diseases shall be based on all patients having presumptive or confirmed diagnosis of a disease as prescribed in §97.5(b) of this title (relating to Prevention of the Spread of Disease from a Case) who, during the reported week:

(1) were newly admitted to a facility, including emergency room;

(2) were admitted to an isolation unit;

(3) were discharged, disease not previously reported;

(4) died, disease not previously reported; or,

(5) were evaluated in an out-patient unit.

(e) Official reports of preliminary nature shall be held by the local health authority until a final diagnosis has been made.

(f) Reporting of a case of communicable disease by a hospital shall be in addition to, and not as a substitute for, the reporting required of the attending physician or other persons having knowledge of the case.

§97.4. Physicians to Report Diseases

(a) It is hereby made the duty of every physician holding a license to practice medicine in the State of Texas to report to the local health authority, immediately after his or her first professional visit, each patient he or she shall examine and who has or is suspected of having any reportable disease, as prescribed in §97.1 of this title (relating to Definitions), and to report any recognized outbreak of illness of any kind whether or not the disease is known to be communicable or reportable. A physician may authorize a member of his staff to transmit reports. The local health authority shall collect the reports and transmit the information at weekly intervals to the Texas Department of Health in a manner prescribed by the commissioner of health. Known or suspected cases of botulism, cholera, diphtheria, plague, louse-borne relapsing fever, paralytic poliomyelitis, smallpox, epidemic typhus, and yellow fever are to be reported immediately and directly to the Texas Department of Health as well as to the local health authority. When a case or outbreak of communicable disease is reported to a local health authority, and the person or persons diagnosed as having the disease reside outside his area of local health jurisdiction, the local health authority receiving the report shall notify the appropriate local health authority where the person or persons reside. He shall also notify the local health authority of any other area where, in his opinion, transmission of the disease may have occurred. The Texas Department of Health shall assist the local health authority in providing such notifications if requested. The local health authority of the area where the case or outbreak is diagnosed shall report the case or outbreak to the Texas Department of Health on the same basis as other reports.

(b) The local school authorities shall report to the local health authority those children attending school who are suspected of having a reportable disease. Procedures for determining which children should be so suspected and reported, and for their exclusion from school pending appropriate medical diagnosis or recovery, shall be defined by the local health authority according to policies established by the commissioner of health.

(c) When a physician is not in attendance, or when a case of a reportable disease has for any reason not been reported, it shall be the duty of every professional registered nurse; every medical laboratory director; every military installation, military or other federally-operated hospital, clinic, jail or detention center; every superintendent, principal, teacher, school health official, or counselor of a public or private school; every administrator or health official of

a public or private institution of higher learning; every owner or manager of a restaurant, dairy, or other food-handling or food-processing establishment or food outlet; every superintendent, manager, or health official of a public or private camp, home, or institution; every parent, guardian, or householder; every professional health worker or other person having knowledge of any person affected with any disease apparently or presumably communicable to notify at once the local health authority or the Texas Department of Health of all facts in relation to the illness and physical condition of any such person.

§97.5. Prevention of the Spread of Disease from a Case.

(a) *General.* It shall be the duty of the local health authority upon identification of a case or upon receipt of notification or report of such diseases to take such action and measures as may be necessary according to any policies which may be established by the commissioner of health, within the provisions of these rules and regulations, to prevent the spread of any communicable disease to other people.

(b) *List of reportable diseases.* There will be publicly declared by the Texas Board of Health, from time to time as is expedient and as necessity requires and the public health demands, a list of diseases to be reportable and, when any disease is so declared to be a reportable disease, the regulations herein provided shall apply to all listed diseases as if each had been specifically listed as reportable herein. The information required to be reported for each disease will be specified in the list. (The organization of diseases into categories for immediate reportings, weekly reporting, reporting by numeric totals vs. name, address, age, sex, race, etc., is all accomplished by the list.)

(c) *Notification of school authorities.*

(1) Whenever any local health authority is notified of the existence of any communicable disease in any household, it shall be his duty to notify officially the appropriate county or city superintendent of schools, or the principal of any school not under the jurisdiction of the city or county board of education and patronized by a member or members of the infected household. The local health authority shall prohibit the attendance of any person from the infected household at any public or private school when and for such a period of time as, in his opinion, there is danger of such persons transmitting infection.

(2) Whenever a local health authority notifies the county or city superintendent of schools or the principal of any school not under the jurisdiction of a city or county board of education of the existence of disease in a communicable stage in any household sending children to public or private schools within his jurisdiction, he shall notify the principal or teacher of said school to refuse admission to any pupil residing in such infected household until such pupil or pupils shall comply with readmission

procedures as stated in Section §97.2(c) of this title (relating to Diseases Requiring Exclusion from School).

(3) Parents, guardians, and others in charge of any household wherein exists any diseases in a communicable stage shall not allow any child or other person residing therein to attend any private or public school until readmitted as stated in Section §97.2(c) of this title (relating to Diseases Requiring Exclusion from School).

(d) *Closure of school and places of public or private assembly.* The local health authority is empowered to close any public or private school or other place of public or private assembly when in his opinion such closing is necessary to protect the public health; and such school or other place of public or private assembly shall not reopen until permitted by the health authority who caused its closure.

§97.6. Quarantine of Diseases, Persons, and of Contacts within Specific Premises

The local health authority is hereby empowered and it is made his duty that whenever a case of communicable disease occurs in any household or place within his jurisdiction, and it is in his opinion necessary or advisable in order to protect the public health that persons residing therein shall be kept from contact with the public, to declare the house, building, apartment, room, or place wherein the case occurs to be a place of quarantine, and to require that no person shall leave or enter said quarantine place during the period of quarantine except with specific permission of the health authority who declared such quarantine.

§97.7. General Control Measures for Reportable Diseases

Except for diseases for which equivalent measures of investigation and control are specifically provided in other sections of these regulations, it shall be the duty of the local health authority or his duly authorized representative to proceed as follows:

(1) Investigation shall be made as the circumstances may require for the purpose of verification of the diagnosis, ascertaining the source of the causative agent, disclosing unreported cases, and revealing contacts.

(2) Laboratory specimens of the body tissues, fluids, or discharges, and of materials directly or indirectly associated with the case, as may be necessary or desirable in confirmation of the diagnosis or for ascertaining the source of the infection, shall be collected and submitted to a laboratory for examination.

(3) Control techniques, including disinfection, environmental sanitation, artificial immunizations, and other recognized measures, shall be instituted as may be necessary to reduce morbidity and mortality. In establishing quarantine or isolation, the local health authority shall designate and define the limits of the areas in which the persons are quarantined or isolated.

(4) Information concerning the disease and its prevention shall be given to the patient or a responsible member of his household to prevent further spread of said disease.

(5) Control measures implemented by the local health authorities shall be at least as stringent as those established by the commissioner of health and shall be subject to review and alteration by the commissioner of health.

§97.8. Specific Control Measures for Certain Reportable Diseases

(a) The local health authority shall place cases of infectious diseases in isolation as may be necessary for protection of the public health. The commissioner of health shall provide sufficient guidance to recommend appropriate infectious disease control measures for institution by all local health authorities.

(b) The following diseases are subject to international quarantine and special isolation procedures may be necessary:

(1) *Cholera.*

(A) *Isolation.* Special isolation of patient beyond routine hospitalization is not necessary.

(B) *Quarantine.* The patient may not be released from the hospital except under special orders from the commissioner of health.

(2) *Plague (bubonic or pneumonic).*

(A) *Isolation.* Hospitalize all patients if practical; take reasonable aseptic precautions for patients with bubonic plague, and require strict isolation for primary pneumonic plague or for any patient developing pneumonic plague.

(B) *Quarantine.* Contacts of pneumonic plague must be quarantined for 6 days with close surveillance for developing illness; contacts and their clothing must be freed of arthropod vectors.

(C) *Disinfection.* Persons at risk of being bitten by infected fleas shall be protected by procedures to kill fleas, according to recommendations which may be established by the commissioner of health.

(3) *Smallpox.*

(A) *Isolation.* Isolation in screened wards or rooms until all scabs and crusts have disappeared.

(B) *Quarantine.* All persons living or working on the same premises as or otherwise having intensive exposure to the person who develops smallpox, shall be considered contacts, and promptly vaccinated or revaccinated, or quarantined for 16 days from last exposure. If such contacts are considered immune by reason of prior attack or successful revaccination within the previous three years, they shall be kept under surveillance until the height of the reaction to the recent vaccination has passed. If the contact is not considered immune, he shall be kept under surveillance until 16 days have passed since the last contact. Any rise in temperature during surveillance calls for prompt isolation until smallpox is excluded.

(4) *Yellow Fever.*

(A) *Isolation.* None: Prevent access of mosquitoes to patient during first three days by using screened sickroom or by spraying quarters with insecticide having residual effect.

(B) *Quarantine.* None.

(5) *Diphtheria.*

(A) *Isolation.* Until two sets of throat cultures from nose and throat taken not less than 24 hours apart and not less than 24 hours after cessation of antimicrobial therapy fail to show diphtheria bacilli. Where culture is impractical, isolation may be ended after 14 days following onset of disease.

(B) *Concurrent disinfection.* All articles in contact with patient and all articles soiled by discharges of patient shall be disinfected.

(C) *Quarantine.* All intimate contacts shall be placed under modified quarantine until nose and throat cultures are negative. All carriers shall be treated with appropriate antimicrobial therapy, as if they were cases. Adult contacts whose occupation involves either handling of food or close association with children must be excluded from those occupations until bacteriologic examination proves them not to be carriers.

(D) *Immunization of contacts.* Contacts intimately exposed and not previously immunized with toxoid shall be given the first dose of toxoid and an appropriate antibiotic if culture is positive or shall be placed under appropriate quarantine measures for a period of seven days, or both. Both children and adults will be examined daily by a physician for no less than seven days and provided with such further immunization as may be necessary to confer full protection. Contacts previously immunized with toxoid shall have a booster dose of toxoid or shall be placed under appropriate quarantine measures for a period of seven days or both.

(E) *Investigation of contacts.* Unreported cases, carriers, and atypical cases among intimate contacts will be identified, reported, and treated as in the foregoing provisions.

(6) *Tuberculosis.*

In all cases of infectious tuberculosis, the local health authority may isolate the case until it is either non-

infectious or in his opinion no longer dangerous to the contacts (refer Texas Civil Statutes, article 4477-11).

(7) *Paralytic poliomyelitis.*

(A) *Isolation.* Patients shall be hospitalized. Contact with unimmunized hospital staff and others shall not be permitted for seven days.

(B) *Disinfection.* Throat discharges and feces and articles soiled therewith shall be discharged directly into toilets attached to sanitary sewers or be disinfected by means approved by the commissioner of health.

(C) *Contacts.* All non-immune persons known to be exposed to paralytic poliomyelitis shall submit to quarantine ordered by the local health authority in order that early symptoms of new cases may be detected and that spread may be prevented.

(D) *Prevention.* The commissioner of health in coordination with appropriate local health authority may order immunization with vaccines and/or quarantine for susceptibles exposed to an infectious case of paralytic poliomyelitis for a period of no more than 21 days following exposure to an infectious individual.

(8) *Animal rabies.*

Rules and regulations for the prevention and control of animal rabies are promulgated in compliance with Texas Civil Statutes, article 4477-6a.

(c) *Declaration of the existence of an epidemic:* The local health authority or the commissioner of health may declare the existence of an outbreak or epidemic of any disease, identified or unidentified, occurring within the approximate confines of any locality.

§97.9. Confidential Nature of Case Reporting

(a) All individual morbidity case reports received by the local health authority or the Texas Department of Health are to be considered confidential records and not public records.

(b) Health records, public and private are subject to confidential review by the delegated agent of the local health authority and/or the commissioner of health who shall determine that review of those records is necessary for the protection of the public health may be provided to the Texas Department of Health as provided by law.

Courses of Study**Section BB-6.0**

Tex. Educ. Code Ann., §21.101 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.101. Required Curriculum

(a) Each school district that offers kindergarten through grade 12 shall offer a well-balanced curriculum that includes:

(1) English language arts;

(2) other languages, to the extent possible;

(3) mathematics;

(4) science;

(5) health;

(6) physical education;

- (7) fine arts;
- (8) social studies;
- (9) economics, with emphasis on the free enterprise system and its benefits;
- (10) business education;
- (11) vocational education; and
- (12) Texas and United States history as individual subjects and in reading courses.

(b) The State Board of Education by rule shall designate subjects comprising a well-balanced curriculum to be offered by a school district that does not offer kindergarten through grade 12.

(c) The State Board of Education by rule shall designate the essential elements of each subject listed in Subsection (a) of this section and shall require each district to provide instruction in those elements at appropriate grade levels. In order to be accredited, a district must provide instruction in those essential elements as specified by the state board.

(d) Local instructional plans may draw upon state curriculum frameworks and program standards as appropriate. The responsibility for enabling all children to participate actively in a balanced curriculum which is designed to meet individual needs rests with the local school district. Districts are encouraged to exceed minimum requirements of the law. A primary purpose of the public

school curriculum in Texas shall be to prepare thoughtful, active citizens who understand the importance of patriotism and can function productively in a free enterprise society with appreciation for the basic democratic values of our state and national heritage.

(e) The State Board of Education shall provide for optional subjects in addition to those provided by Subsection (a) of this section as appropriate for districts that require choices in order to address unique local needs. In addition, the commissioner of education may permit a school district to vary from the required curriculum as necessary to avoid hardship to the district.

(f) Not later than the 30th day preceding the day on which each regular session of the legislature convenes, the State Board of Education shall transmit to the governor, the lieutenant governor, and the legislature a report on the status of curriculum in the public schools. The report shall include recommendations for legislative changes necessary to improve, modify, or add to the curriculum.

(g) The State Board of Education and local school districts shall foster the continuation of the tradition of teaching American and Texas history and the free enterprise system in regular subject matter and in reading courses in the public free schools of Texas and in the adoption of textbooks.

Teachers' (Nurses') Employment Contracts

Section BB-7.0

Tex. Educ. Code Ann., §§21.201-21.211 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§§21.201. Definitions

As used in this subchapter, the following terms shall have the meaning ascribed to them in this section.

(1) "Teacher" means a superintendent, principal, supervisor, classroom teacher, counselor, or other full-time professional employee, except paraprofessional personnel, who is required to hold a valid certificate or teaching permit.

(2) "Board" and "board of trustees" means the governing board of a public school district.

(3) "School district" means any public school district in this state.

(4) "Term contract" means any contract of employment for a fixed term between the school district and a teacher.

§21.202. Teacher Evaluations

The board of trustees of each school district shall provide by written policy for the periodic written evaluation of each teacher in its employ at annual or more frequent intervals. Such evaluation shall be considered by the board of trustees prior to any decision by the board not to renew the term contract of any teacher.

§21.203. Nonrenewal of Term Contracts

(a) The board of trustees of each school district may choose not to renew the employment of any teacher employed under a term contract effective at the end of the contract period.

(b) The board of trustees of each school district shall establish policies consistent with this subchapter which shall establish reasons for nonrenewal.

(c) The board of trustees of each school district shall establish policies and procedures for receiving recommendations from its school administration for the nonrenewal of teacher term contracts, excepting only the general superintendent of schools.

§21.204. Notice

(a) In the event the board of trustees receives a recommendation for nonrenewal, the board, after consideration of the written evaluations required by Section 21.202 of this subchapter and the reasons for the recommendation, shall, in its sole discretion, either reject the recommendation or shall give the teacher written notice of the proposed nonrenewal on or before April 1 preceding the end of the employment term fixed in the contract.

(b) In the event of failure to give such notice of proposed nonrenewal within the time herein specified, the board of trustees shall thereby elect to employ such employee in the same professional capacity for the succeeding school year.

(c) The notice of proposed nonrenewal required in this section shall contain a statement of all the reasons for such proposed action.

§21.205. Hearing

(a) If the teacher desires a hearing after receiving notice of the proposed nonrenewal, the teacher shall notify the board of trustees in writing within 10 days after receiving the notice of nonrenewal. The board shall provide for a hearing to be held within 15 days after receiving written notice from the teacher requesting a hearing. Such hearing shall be closed unless an open hearing is requested by the employee.

(b) The hearing shall be conducted in accordance with rules promulgated by the district.

§21.206. Decision of Board

(a) If the teacher fails to request a hearing, the board shall take such action as it deems lawful and appropriate and shall notify the employee in writing of that action within 15 days of the expiration of the 10-day period for requesting a hearing.

(b) If the teacher requests a hearing, the board shall take such action as it deems lawful and appropriate and shall notify the teacher in writing of that action within 15 days following the conclusion of the hearing.

§21.207. Appeal

(a) If the teacher is aggrieved by the decision of the board of trustees, he may appeal to the State Commissioner

of Education pursuant to Section 11.13 of this code. The commissioner may not substitute his judgment for that of the board of trustees, unless the decision below was arbitrary, capricious, unlawful, or not supported by substantial evidence.

(b) The State Board of Education shall have jurisdiction to hear appeals from such decisions of the State Commissioner of Education.

§21.208. Superintendents

If a majority of the board of trustees of any school district shall determine that the term contract of the general superintendent of school should be considered for nonrenewal, the provisions of this subchapter shall apply, except that there need not be a recommendation from the designated school administration.

§21.209. Probation

The board of trustees of any school district may provide by written policy for a probationary period not to exceed the first two years of continuous employment in the district, in which case the provisions of this subchapter shall not apply during such probationary period.

§21.210. Discharge for Cause

Nothing in this subchapter shall prohibit a board of trustees from discharging a teacher for cause during the term of the contract.

§21.211. Exemptions

This subchapter does not apply to teachers who are employed under the provisions of the probationary or continuing contract law as set out in Subchapter C of Chapter 13 of this code.

Protective Eye Devices in Public Schools

Section BB-8.0

Tex. Educ. Code Ann., §21.909 (Vernon Supp. 1975). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.909.

(a) Industrial quality eye-protective devices shall be worn by every teacher and pupil in Texas participating in any of the following courses:

(1) vocational or industrial arts shops or laboratories involving experience with:

- (A) hot molten metals;
- (B) milling, sawing, turning, shaping, cutting or stamping of any solid materials;
- (C) heat treatment, tempering, or kiln firing of any metal or other materials;
- (D) gas or electric arc welding; or
- (E) caustic or explosive materials; or

(2) chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids.

(b) In this section, "industrial quality eye-protective devices" means devices meeting the standards set by the State Department of Health.

(c) The governing boards and administrators of Texas school districts offering any of the listed courses are responsible for furnishing free of charge or providing at cost to teachers and pupils participating in the courses the required eye-protective devices.

(d) Whenever an accident occurs during the conduct of any of the courses described in Subsection (a) of this

section, and an injury to the eye of a teacher or pupil results, the principal shall make a full written report of the accident and injury to the State Department of Education.

The department shall prescribe the form and content of the reports and shall maintain a file of all reports submitted.

Fire Escapes

Section BB-9.0

Tex. Rev. Civ. Stat. Ann., Arts. 3955, 3959 (Vernon Supp. 1966). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

Art. 3955. Owner to Provide

The owner of each building, which is or may be constructed within this State, three or more stories in height or in case of schoolhouses two or more stories in height, constructed, used, or intended to be used in whole or in part as any of the following buildings, shall provide and equip such buildings with at least one adequate fire escape, and such additional fire escapes, as provided in the three succeeding Articles.

Art. 3959. State, County, City and School Buildings [Sec. A omitted]

B. Each school building which is or may be constructed within this State of two (2) or more stories in height, which is owned by any school district, and in which schools of any kind are conducted, shall be provided and equipped with an adequate fire escape or fire escapes to the extent and in accordance with requirements as follows:

Definitions

The following terms, words, and phrases as used in subdivision B of this Article shall have the following meanings unless a different meaning is plainly required by the context:

a. "Story" means the space included between two (2) successive floor levels except that a basement shall be construed as a story only when the floor level immediately above the basement is ten (10) feet or more above grade line on one or more sides of the building.

b. Types of construction shall be, for purpose of application of this law, classified as follows: "Fireproof," "semi-fireproofed," and "ordinary" as defined in the latest edition of the Building Code Recommended by the National Board of Fire Underwriters.

Number and Types of Fire Escapes Required

a. Any school building three (3) stories or more in height of "fireproof construction," "semi-fireproof construction," or "ordinary construction" shall have one fire escape for every two hundred and fifty (250) pupils or major fraction thereof housed in the building above the first floor.

b. Any school building two (2) stories in height of "ordinary" construction shall have one fire escape for every two hundred and fifty (250) pupils housed above the first floor, or major fraction thereof.

c. Fire escapes for school buildings heretofore constructed may be either of the interior type, specifications for which are now provided in Article 3966, Title 63, Revised Civil Statutes, 1925, or exterior type as in this amendment hereinafter described. Exterior type fire escapes shall be free from obstruction, shall be constructed so as to secure a safe exit for children, shall be conveniently accessible from each floor above first, and shall be of sufficient width and strength so that each step and landing may accommodate two (2) adult persons at the same time. The exits from each floor shall consist of doorways, the base of which shall be at the same level as the corresponding floor of such building and the landing of the fire escape to which it leads, provided the State Department of Education approves such to be a convenient and safe passage. Each such doorway shall be not less than three (3) feet wide nor less than six (6) feet six (6) inches high, and shall be fitted with panic hardware approved by the National Board of Fire Underwriters. If there shall be two (2) or more rooms or hallways, or room and hallway, adjoining and convenient to the landing of a fire escape, each such room or hallway shall have a doorway leading to such landing.

d. Fire escapes for new school building of three (3) stories or more in height, of "fireproof" construction, shall be interior, specifications for which are now provided in Article 3966, Title 63, Revised Civil Statutes, 1925.

New school buildings hereinafter constructed and existing school buildings heretofore constructed of two (2) stories and less in height, of "fireproof" or "semi-proof" construction, or having stairways and hallways of either of these types shall not be required to have fire escapes.

New school buildings hereinafter constructed of two (2) stories or more in height of "ordinary" construction shall have interior types of fire escapes, specifications for which are now provided in Article 3966, Title 63, Revised Civil Statutes, 1925.

Description of Fire Escapes

a. Exterior fire escapes for the purpose of subdivision B of this amended Article shall be of the following construction, or similar ones approved by the National Board of Fire Underwriters.

(1) They shall be of incombustible materials throughout.

(2) They shall be designed for a live load of one hundred (100) pounds per square foot. The calculated live load

shall be clearly stated on the plans submitted for approval.

(3) As a rule, fire escapes shall be supported by vertical steel columns. Where such construction is not possible because of conditions the use of steel brackets with bolts extending through the entire thickness of the wall may be approved.

(4) Landings and treads shall be of solid hatched steel plate or of steel gratings with interstices not exceeding three-fourths ($\frac{3}{4}$) inches and so designed that the accumulation of snow and ice will be reduced to a minimum.

(5) Guard rails shall be at least three (3) feet six (6) inches in height and shall be substantially constructed. They shall be faced with heavy wire mesh, or steel balusters or rails not more than nine and one-half ($9\frac{1}{2}$) inches o.c. may be used.

(6) There shall be handrails on each side of the stairs, securely attached to the guard rails or to the building walls. Handrails shall be two (2) feet four (4) inches to two (2) feet six (6) inches above the nosings.

(7) On present existing structures exterior type fire escapes, for the purpose of subdivision B of this amended Article, shall be an iron, steel or concrete stairway type fire escape, or an iron or steel straight chute type fire escape, or an iron or steel spiral chute type fire escape, or a combination of said three (3) types of fire escapes.

(8) Exterior type fire escapes, for the purpose of subdivision B of this amended Article, may be an iron or steel straight chute type fire escape or an iron or steel spiral chute type fire escape.

b. Design of interior fire escapes in addition to the

specifications set out in Article 3966, Title 63, Revised Civil Statutes, 1925, shall be as follows:

(1) Stairs and landings shall be not less than three (3) feet six (6) inches long and not less than three (3) feet wide.

(2) Treads shall be not less than nine (9) inches wide plus a nosing of one (1) inch. Risers shall be not more than seven and one-fourth ($7\frac{1}{4}$) inches.

(3) There shall be not more than a nine (9) foot six (6) inch rise in a single run. Longer runs shall be interrupted by landings at least as deep as the width of the stairs.

(4) Stairs shall extend continuously to the ground. Counter-balanced and swinging sections will not be approved.

c. Exits of exterior fire escapes shall be as follows:

(1) Doors leading to fire escapes shall open on landings at least the width of the doors.

(2) Exit doors shall swing outward, shall be at least three (3) feet no inches by six (6) feet six (6) inches, shall be glazed with wire glass, and shall have their bottoms level with the floors of the rooms or corridors and landings they serve. Windows are prohibited as means of access to fire escapes.

(3) Exit doors shall be secure only by panic hardware approved by the National Board of Fire Underwriters. Hooks, latches, bolts, locks, etc. are prohibited.

d. Windows located beneath or within ten (10) feet in any direction of fire escapes shall be glazed with wire glass.

Requirements for District Participation in the Foundation School Program Fund

Section BB-10.0

Tex. Educ. Code Ann., Chapter 16, Subchapter B, §§16.051-16.055 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§16.051. Required Compliance

In order to receive financial support from the Foundation School Fund, a school district must comply with the standards set forth in this subchapter.

§16.052. Operation of Schools

(a) Each school district must provide for not less than 175 days of instruction for students and not less than 10 days of inservice training and preparation for teachers for the 1977-78 school year and not less than 175 days of instruction for students and not less than eight days of inservice training and preparation for teachers for each school year thereafter, except as provided in Subsection (b) of this section.

(b) The commissioner of education may approve the operation of schools for less than the number of days of instruction and inservice training and preparation otherwise required when disasters, floods, extreme weather con-

ditions, fuel curtailments, or other calamities have caused the closing of the school.

§16.053. Accreditation

Beginning with the 1977-1978 school year each school district must be accredited by the Central Education Agency.

§16.054. Student/Teacher Ratios

Each school district must employ a sufficient number of certified teachers to maintain an average ratio of not less than one teacher for each 25 students in average daily attendance.

§16.055. Compensation of Professional and Para-professional Personnel

(a) A school district must pay each employee who is qualified for and employed in a position classified under

the Texas Public Education Compensation Plan set forth in Section 16.056 of this chapter not less than the minimum monthly base salary, plus increments for teaching experience, specified for the position.

(b) Contracts for personnel shall be made on the basis of a minimum of 10 months' service, which must include the number of days of instruction for students and days of inservice training and preparation for personnel required by Section 16.052 of this code. The days of inservice training and preparation required herein shall be conducted by local boards of education under rules and regulations established by the State Board of Education that are consistent with the state accreditation standards for program planning, preparation, and improvement. Personnel

employed for more than 10 months shall be paid not less than the minimum monthly base pay plus increments for experience for each month of actual employment. Personnel employed for 11 months at pay grades 1-11 must render 202 days of service, and personnel employed for 12 months at pay grades 1-11 must render 220 days of service. Personnel employed for 11 months at pay grades 12-18 must render 207 days of service, and personnel employed for 12 months at pay grades 12-18 must render 226 days of service. However, the number of days of service required by this subsection may be reduced by the commissioner under Section 16.052(b) of this code, and the reduction shall not reduce the total salaries of personnel.

Coordination of Services to Handicapped Children Section BB-11.0

Tex. Educ. Code Ann., §11.103 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§11.103.

(a) In this section "handicapped children" has the meaning defined in Section 16.104(b) of this code.

(b) The commissioner of education, with the approval of the State Board of Education, shall develop and implement a plan for the coordination of services to handicapped children within each geographical area served by a regional education service center. The plan shall include, but may not be limited to, procedures for:

(1) identifying existing public or private educational and related services for handicapped children in each region;

(2) identifying and referring handicapped children who cannot be appropriately served by the school district in which they reside to other appropriate programs;

(3) assisting school districts individually and cooperatively to develop programs to identify and provide appropriate services for handicapped children;

(4) expanding and coordinating services provided by regional education service centers which are related to programs for handicapped children; and

(5) providing for special services such as special seats, books, instructional media, and other supplemental supplies and services required for quality instruction.

(c) The commissioner may allocate appropriated funds to regional education service centers and may otherwise expend those funds, as necessary, to implement the provisions of this section.

Coordinated Health Program (Cooperation in Establishment of Program)

Section BB-12.0

Tex. Rev. Civ. Stat. Ann., Art. 4447a, §1 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§1.

The Commissioners Court of any one or more counties and the municipal authorities of any one or more cities, towns, school boards and school districts, and any other governmental entity may cooperate in the establishment of a Health District and by mutual agreement may pro-

vide for the payment of costs, including the salaries of persons employed, materials used, and the provision of suitable office quarters, health and clinic centers, health services and facilities thereof, and for all maintenance purposes.

Health and Safety

Section BB-13.0

*19 Tex. Admin. Code §61.91 (McGraw-Hill, 1981).***§61.91. Student Health, Safety, and Well-Being**

It shall be the responsibility of school districts to adopt and implement policies designed to protect and promote the health, safety, and well-being of its pupils. These policies shall include, but shall not be restricted to, the following items:

(1) Provisions shall be made for the examination for tuberculosis infection of students when the need for such examination is indicated, in accordance with guidelines for the Texas State Department of Health.

(2) Provisions shall be made for implementation of an immunization program in accordance with the requirements of law and the rules of the Texas State Department of Health and the State Board of Education. (Reference Texas Education Code §2.09.)

(3) Eye-protective devices shall be provided in accordance with Texas Education Code §21.909.

Health Services

Section BB-14.0

*19 Tex. Admin. Code §85.41 (McGraw-Hill, 1981).***§85.41. Health Services Program**

(a) School health services shall be considered as part of the educational program of the school children of Texas. These services shall be provided to all children through local education agencies, in accordance with the provisions of Subchapter D of Chapter 97 of this title (relating to Principles, Standards, and Procedures for the Accreditation of School Districts), and standards established by the Texas State Department of Health and in accordance with applicable laws. The local education agency shall ensure appropriate coordination of school health services, other student services, and related instructional programs.

(b) School health services shall be addressed by policies of the local board of trustees. Local policies shall address the following functions:

(1) planning, development, and evaluation;

(2) health counseling;

(3) screening;

(A) vision (Texas Civil Statutes, Article 4419f);

and

(B) hearing;

(4) prevention and control of communicable diseases;

(A) immunization (Texas Education Code, §2.09); and

(B) exclusion and reporting of students or employees who have communicable diseases (Texas Civil Statutes, Article 4477);

(5) provision for emergency cases;

(6) consultation and coordination with other student services and related instructional programs to focus on the health-related needs of students and their families (including but not limited to special education and health education);

(7) liaison with community health resources;

(8) referral and follow-up to ensure that parents have been notified of identified problems and know how they can obtain needed services for their children;

(9) health appraisals of students;

(10) maintenance of pupil health records;

(11) reporting child abuse (Texas Civil Statutes, Article 3401 et seq.);

(12) administration of medication by school personnel (Texas Education Code, §21.914); and

(13) eye-injury reporting and eye-protective devices (Texas Education Code, §21.909).

Immunization Requirements in Texas

Section BB-15.0

Elementary and Secondary Schools and Institutions of Higher Education*25 Tex. Admin. Code §§97.61-97.77 (McGraw-Hill, 1981).***§97.61. Students Included in Requirements**

The immunization requirements are specified elsewhere in this policy statement and apply to all students

entering, attending, and/or transferring to public, private, or parochial schools, for example: preschool programs and kindergartens associated with elementary schools; elemen-

tary and secondary (junior and senior high) schools; academies, colleges; universities; and, schools for the blind, deaf, mentally ill, and mentally retarded.

§97.62. Exclusions from Compliance

Exclusions from compliance are allowable on an individual basis for medical contraindications; religious conflicts, and active duty with the armed forces of the United States. Students in these categories must submit evidence as specified in the law.

(1) *Medical contraindications.* The student must present an affidavit or a certificate signed by a physician, duly registered and licensed to practice medicine in the United States, in which it is stated that, in the physician's opinion, the immunization required would be injurious to the health and well-being of the applicant or any member of his or her family or household. Unless a lifelong condition is specified, the affidavit or certificate is valid only one year from the date signed by the physician, and must be renewed at that time for the exclusion to remain in effect.

(2) *Religious conflicts.* The student must present an affidavit signed by the applicant, or if a minor, by his or her parent or guardian stating that the immunization conflicts with the tenets and practice of a recognized church or religious denomination of which the applicant is an adherent or member; provided, however, that this exemption does not apply in times of emergency or epidemic declared by the commissioner of health.

(3) *Armed forces.* Students who can prove that they are serving on active duty with the armed forces of the United States are exempted from the requirements in this title.

§97.63. Required Immunizations

See §97.71 of this title (relating to Provisional Enrollment), and §97.77 of this title (relating to Remarks and Special Recommendations).

(a) The immunization of infants and young children often requires a larger number of doses of vaccine than does the immunization of older children and adults. This section establishes minimum requirements (three doses each) for immunization against diphtheria, tetanus, pertussis, and poliomyelitis for the admission of school-age children to schools. These requirements should in no way be interpreted as contrary to standing recommendations by this department or by the Academy of Pediatrics, which call for larger numbers of doses (four or five doses each) to be employed in the immunization of infants and young children against these diseases.

(b) Oral polio vaccine is the usual vaccine of choice for preventing polio; however, inactivated polio vaccine may be medically indicated for some students. The required number of doses and booster requirements for inactivated polio vaccine (IPV) differ from the requirements

for oral polio vaccine. (See §97.66 of this title (relating to Inactivated Polio Vaccine).) If a student fails to complete the oral polio vaccine series, and, upon medical advice, starts receiving IPV, then the IPV requirements specified in §97.66 of this title (relating to Inactivated Polio Vaccine) will apply.

(c) The following immunizations are required in the respective age groupings.

(1) Children less than five years of age.

(A) Children less than two months old: no immunizations required.

(B) Children two months of age, but not yet four months of age: one dose each of oral polio and diphtheria-tetanus-pertussis (DTP) vaccines.

(C) Children four months of age, but not yet six months of age: two doses each of oral polio and DTP vaccines.

(D) Children six months of age, but not yet 18 months of age: two doses of oral polio and three doses of DTP vaccines.

(E) Children 18 months of age, but not yet five years of age: three doses each of oral polio and DTP vaccines, and one dose each of measles and rubella vaccines. The dose of measles vaccine must have been received on or after the first birthday or during the calendar month of the first birthday; or a physician-validated history of measles illness must be provided. All children in this group must have also received mumps vaccine, or provide a physician-validated history of mumps illness. See §97.67 of this title (relating to Verification of Measles or Mumps Illness), for policies on the acceptance of histories of measles and/or mumps illnesses in lieu of the vaccines.

(2) Children or students five years of age or older enrolled in elementary or secondary schools. (See §97.65 of this title (relating to Pregnancy).)

(A) *Polio.* At least three doses of oral polio vaccine are required, provided at least one dose has been received on or after the fourth birthday. See §97.77(c) and (d) of this title (relating to Remarks and Special Recommendations). Polio vaccine is not required for persons 18 years of age or older.

(B) *Tetanus/diphtheria.* At least three doses of DTP and/or Td vaccines are required, provided at least one dose has been received on or after the fourth birthday. See §97.64(b) of this title (relating to Boosters), and §97.77(c) and (d) of this title (relating to Remarks and Special Recommendations).

(C) *Measles.* All students in this group must have received measles vaccine on or after the first birthday, or during the calendar month of the first birthday and since January 1, 1968, or provide a physician-validated history of measles illness. See §97.67 of this title (relating to Verification of Measles Illness).

(D) *Rubella*. One dose of rubella vaccine is required. Rubella vaccine is not required past the 12th birthday. See §97.77(f).

(E) *Mumps*.

Beginning September 1, 1981, all children or students nine years of age or less on September 1, 1981, will be required to have received mumps vaccine, or provide a physician-validated history of mumps illness. See §97.67 of this title (relating to Verification of Mumps Illness). On the first of September each year thereafter, children or students one year older as of September 1 of that year, will also be required to have received mumps vaccine or provide a physician-validated history of mumps illness. See the following table:

Effective Dates	Ages as of September 1
September 1, 1981	Thru 9
September 1, 1982	Thru 10
September 1, 1983	Thru 11
September 1, 1984	Thru 12
September 1, 1985	Thru 13
September 1, 1986	Thru 14
September 1, 1987	Thru 15
September 1, 1988	Thru 16
September 1, 1989	Thru 17
September 1, 1990	Thru 18 and older

(3) Students in institutions of higher education. See §97.65 of this title (relating to Pregnancy) and §97.77 (f) of this title (relating to Remarks and Special Recommendations).

(A) *Polio*. Polio vaccine is not required for persons eighteen years of age and older. For persons less than eighteen years of age, at least three doses of oral polio vaccine are required, of which at least one dose must have been received on or after the fourth birthday. See §97.77(c)(d).

(B) *Tetanus/diphtheria*. A minimum of three doses of Td is required, of which the last dose was administered within ten years. DTP doses may be credited to the three required doses. See §97.77(c)(d).

(C) Students in institutions of higher education may be exempted from the requirements of this title by their respective institutions.

§97.64. Boosters

(a) Boosters are not required for oral polio, rubella, and mumps vaccines.

(b) Reinforcing of "booster" doses of tetanus/diphtheria (Td) vaccine are required every 10 years after the dose obtained on or after the fourth birthday. See §97.63(2)(B).

§97.65. Pregnancy

Requirements for polio, measles, rubella, and mumps vaccines are waived during pregnancy. This does not apply to tetanus/diphtheria vaccine.

§97.66. Inactivated Polio Vaccine

This vaccine is the injectable type which is usually recorded as "IPV" or "Salk" on immunization records. A few students may need this type of polio vaccine instead of oral polio vaccine because of medical considerations. A student may be provisionally enrolled with a history of one dose of IPV, provided two more doses are taken at one- to two-month intervals, and a fourth dose is received six to 12 months later. A student will be in full compliance with the IPV requirements whenever he or she has received the four initial IPV doses and has received a dose every five years until the 18th birthday. If a student fails to receive the five-year IPV booster, but, upon medical advice, starts receiving oral polio vaccine, then the oral polio vaccine requirements specified in §97.63 will apply to the student.

§97.67. Verification of Measles or Mumps Illness

Section 97.63 of this title (relating to Required Immunizations) states that physician-validated histories of measles or mumps illnesses are acceptable in lieu of vaccine. All histories of measles or mumps illness must be supported by a written statement from a physician licensed to practice medicine in the United States. The physician's statement should contain wording such as "This is to verify that (name of student) had measles or mumps illness on or about (date) and does not need measles or mumps vaccine." A copy of the statement must be attached to the student's school immunization record, and the original returned to the student, parent, or guardian. Note: If a student is unable to submit a physician's statement, then measles or mumps vaccine is required.

§97.68, §97.69, and §97.70 Repealed

§97.71. Provisional Enrollment

The law requires that students be fully immunized against the specified diseases. However, a student may be provisionally admitted if he or she has begun the required immunizations and if he or she continues to receive necessary immunizations as rapidly as is medically feasible. The school granting provisional enrollment must ensure that the required immunizations are received on schedule. If a student transfers from one school to another, a grace period of no more than 30 days may be allowed at the new school while awaiting the transfer of the immunization record, during which the student may be provisionally enrolled.

§97.72. School Records

All schools are required to maintain records of the immunization status of individual students. The records must be made available for inspection by representatives of the Texas Education Agency, the Texas Department of Health, or local health departments, at all reasonable times.

§97.73. Acceptable Documents of Immunizations

Any validated document of immunization presented by a student is acceptable, provided it shows at least the month and year when each immunization was received. At least the month and year of vaccine or disease must be recorded in all new school records initiated, and in existing records updated, after September 1, 1978. The month, day, and year of immunizations or diseases should be recorded whenever possible. All new entries in immunization files must be based upon a certificate of immunization which has been validated by, or for, a physician or public health personnel. The validated record should be returned to the student or the student's parent or guardian after the immunization history has been entered in school records. The Texas Department of Health and local health departments will provide record-keeping cards free of charge for maintaining school immunization files, or commercially or locally produced record cards may be used.

§97.74. Transfer of Records

When a student transfers from one school or district to another, a copy of the immunization record and any measles or mumps illness statements from physicians should be sent within 30 days to the receiving school. A record received by mail from school officials of another district or state may be considered a validated record.

§97.75. Assistance and Review of Records

Representatives of the Texas Department of Health and local health departments will, upon request, advise and assist school administrators in meeting the requirements of the law. Representatives of the Texas Education Agency review immunization records when annual immunization reports are submitted, and again when schools are visited for accreditation purposes. Periodic review of school immunization records is occasionally necessary in order to allow public health epidemiologists to obtain information required in preventing or controlling community outbreaks of vaccine-preventable diseases.

§97.76. Annual Report of Immunization Status

Annual reports of the immunization status of students as of a specified date shall be required of all public school districts and private schools so that compliance with the legislation may be monitored. Data derived from these

reports are published jointly by the Texas Education Agency and the Texas Department of Health.

§97.77. Remarks and Special Recommendations

(a) Immunization recommendations vary from state-to-state and from physician-to-physician. The immunization requirements specified herein will assure protection against the vaccine-preventable diseases for the majority of students. Some physicians and local health departments adhere to an immunization schedule which may require more doses than other physicians; therefore, many students will have received more doses of vaccine than those specified above.

(b) If there is an epidemic of vaccine-preventable disease in or near a community, the local health authority may require or recommend additional doses or boosters to provide further protection for students attending schools and institutions of higher education.

(c) If a dose of oral polio or DTP/Td vaccine is administered within the calendar month prior to, or of, the fourth birthday, it will satisfy the requirement for a dose on or after the fourth birthday.

(d) When a validated immunization record contains only one vaccine date for either oral polio or DTP/Td, and a "B" or the word "booster," or the words "series completed" (or similar wording) appears by the immunization date, assume that three doses of the vaccine have been administered. If the date is within the month prior to, or of, the fourth birthday, then the requirement for a dose on or after the fourth birthdate is met under these circumstances.

(e) The requirements for mumps vaccine will apply to one higher age each year until all students are included.

(f) Rubella immunizations are not required for students 12 years of age and older. Previously unimmunized females 12 and older should be serologically tested for rubella and referred to their usual source of medical care if the tests indicate susceptibility to rubella.

(g) Authorities in schools and institutions of higher education are strongly encouraged to report on the day of recognition all suspected or known cases of vaccine-preventable diseases, which occur among students or staff, to the city or county health department, the city or county health officer, the public health regional office, or the Texas Department of Health in Austin, thus alerting health officials to possible outbreaks of these diseases.

Immunization; Requirements; Exceptions

Section BB-16.0

Tex. Educ. Code Ann. §§2.09, 2.09a (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§2.09.

(a) No person may be admitted to any elementary or secondary school or institution of higher education unless he has been immunized against diphtheria, rubeola, rubella, tetanus, and poliomyelitis, except as provided in Subsection (c).

(b) Subject to the provisions of Subsection (c), the Texas Board of Health may modify or delete any of the immunizations in Subsection (a) or may require immunizations against additional diseases as a requirement for admission to any elementary or secondary school or institution of higher education.

(c) No form of immunization is required for a person's admission to any elementary or secondary school or institution of higher education when the person applying for admission:

(1) submits to the admitting official either of the following:

(A) an affidavit or a certificate signed by a physician who is duly registered and licensed to practice medicine within the United States, in which it is stated that, in the physician's opinion, the immunization required would be injurious to the health and well-being of the applicant or any member of his family or household; or

(B) an affidavit signed by the applicant or, if a minor, by his parent or guardian stating that the immunization conflicts with the tenets and practice of a recognized church or religious denomination of which the applicant is an adherent or member; provided, however, that this exemption does not apply in times of emergency or epidemic declared by the Commissioner of Health; or

(2) is a member of the armed forces of the United States and is on active duty.

(d) The Texas Department of Health shall provide the required immunizations to children in areas where no local provision exists to provide these services.

(e) A person may be provisionally admitted to an elementary or secondary school or institution of higher education if he has begun the required immunizations and if he continues to receive the necessary immunizations as rapidly as is medically feasible. The Texas Department of Health shall promulgate rules and regulations relating to the provisional admission of persons to an elementary or secondary school or institution of higher education.

§2.09a. Immunization Records; Reporting

(a) Each school or institution of higher education covered by this Act shall keep an individual immunization record during the period of attendance for each student admitted, and the records shall be open for inspection at all reasonable times by the Central Education Agency or by representatives of local health departments or the Texas Department of Health.

(b) Each school or institutions of higher education covered by this Act shall cooperate in transferring students' immunization records between other schools and institutions of higher education. Specific approval from students, parents, or guardians is not required prior to making such record transfers.

(c) The Central Education Agency and the Texas Department of Health shall develop the form for a required annual report of the immunization status of students and such annual report shall be submitted by all Texas schools at such time and in such manner as is indicated in the instructions printed on such form.

Duties of Professional Employees; Liability

Section BB-17.0

Tex. Educ. Code Ann. §21.912, (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.912.

(a) The board of trustees of each school district within this state shall adopt policies specifying the duties of each of its professional positions of employment. The board of trustees shall assign positions of employment earned under the minimum foundation program to meet the specific needs of the district.

(b) No professional employee of any school district within this state shall be personally liable for any act incident to or within the scope of the duties of his position of employment, and which act involves the exercise of judgment or discretion on the part of the employee, except in

circumstances where professional employees use excessive force in the discipline of students or negligence resulting in bodily injury to students.

(c) This section is not applicable to the operation, use, or maintenance of any motor vehicle.

(d) "Professional employee," as used in this section, includes superintendents, principals, classroom teachers, supervisors, counselors, and any other person whose employment requires certification and an exercise of discretion.

Consent to Medical Treatment

Section BB-18.0

Tex. Fam. Code Ann. §§35.01, 35.02, 35.03 (Vernon 1975). Tex. Fam. Code Ann. §35.04 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§35.01. Who May Consent

Any of the following persons may consent to medical treatment of a minor when the person having the power to consent as otherwise provided by law cannot be contacted and actual notice to the contrary has not been given by that person:

- (1) a grandparent;
- (2) an adult brother or sister;
- (3) an adult aunt or uncle;
- (4) an educational institution in which the minor is enrolled that has received written authorization to consent from the person having the power to consent as otherwise provided by law;
- (5) any adult who has care and control of the minor and has written authorization to consent from the person having the power to consent as otherwise provided by law; or
- (6) any court having jurisdiction of the child.

§35.02. Consent Form

(a) Consent to medical treatment under Section 35.01 of this code shall be in writing, signed by the person giving consent, and given to the doctor, hospital, or other medical facility that administers the treatment.

(b) The consent must contain:

- (1) the name of the minor;
- (2) the name of one or both parents, if known, and the name of the managing conservator or guardian of the person, if either has been appointed;
- (3) the name of the person giving consent and his relation to the minor child;
- (4) a statement of the nature of the medical treatment to be given; and
- (5) the date on which the treatment is to begin.

§35.03. Consent to Treatment by Minor

(a) A minor may consent to the furnishing of hospital, medical, surgical, and dental care by a licensed physician or dentist if the minor:

- (1) is on active duty with the armed services of the United States of America;
- (2) is 16 years of age or older and resides separate and apart from his parents, managing conservator, or guardian, whether with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of such residence, and is managing his own financial affairs, regardless of the source of the income;
- (3) consents to the diagnosis and treatment of any infectious, contagious, or communicable disease which is required by law or regulation adopted pursuant to law to

be reported by the licensed physician or dentist to a local health officer;

(4) is unmarried and pregnant, and consents to hospital, medical, or surgical treatment, other than abortion, related to her pregnancy;

(5) is 18 years of age or older and consents to the donation of his blood and the penetration of tissue necessary to accomplish the donation; or

(6) consents to examination and treatment for drug addiction, drug dependency, or any other condition directly related to drug use.

(b) Consent by a minor to hospital, medical, surgical, or dental treatment under this section is not subject to disaffirmance because of minority.

(c) Consent of the parents, managing conservator, or guardian of a minor is not necessary in order to authorize hospital, medical, surgical, or dental care under this section.

(d) A licensed physician or dentist may, with or without the consent of a minor who is a patient, advise the parents, managing conservator, or guardian of the minor of the treatment given to or needed by the minor.

(e) A physician or dentist licensed to practice medicine or dentistry in this state or a hospital or medical facility shall not be liable for the examination and treatment of minors under this section except for his or its own acts of negligence.

(f) A physician, dentist, hospital, or medical facility may rely on the written statement of the minor containing the grounds on which the minor has capacity to consent to his own medical treatment under this section.

§35.04. Examination of Abused or Neglected Children

(a) Except as provided in Subsection (b) of this section, a licensed physician or dentist having reasonable grounds to believe that a child's physical or mental condition has been adversely affected by abuse or neglect may examine the child without the consent of the child, the child's parents, or other person authorized to consent for the child or his parents. The examination may include X-rays, blood tests, and penetration of tissue necessary to accomplish these tests.

(b) Unless consent is obtained as otherwise allowed by law, a physician or dentist may not examine a child:

(1) who is 16 years old or over and refuses to consent; or

(2) if consent is refused by an order of a court.

(c) A physician or dentist examining a child under the authority of this section is not liable for damages except those damages resulting from his negligence.

Administering of Medication by School District Employees; Immunity From Liability

Section BB-19.0

Tex. Educ. Code Ann. §21.914 (Vernon Supp. 1982). See *Texas School Law Bulletin* 1982, TEA Pub. AD1 013 01.

§21.914.

(a) As used in this section, "employees" means superintendents, principals, classroom teachers, supervisors, counselors, registered nurses, teachers aides, secretaries, or any other classified person employed by a school district.

(b) The board of trustees of each school district shall adopt policies concerning the administering of medication to students by employees of the district.

(c) On the adoption of policies as provided in Subsection (b) of this section, the school district, its board of trustees, and its employees shall have immunity from civil

liability from damages or injuries resulting from the administering of medication to a student, if:

(1) the school district has received a written request to administer the medication from the parent, legal guardian, or other person having legal control of the student; and

(2) when administering prescription medication, the medication appears to be in the original container and to be properly labeled.

(d) Nothing herein shall be construed to grant immunity from civil liability for injuries resulting from gross negligence.

Nurse Practice Act (Registered Nurse)

Section BB-20.0

Tex. Rev. Civ. Stat. Ann., Art. 4518 §5 (Vernon Supp. 1982).

§5.

Insofar as any of the following acts require substantial specialized judgment and skill and insofar as the proper performance of any of the following acts is based upon knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing, 'Professional Nursing' shall be defined as the performance for compensation of any nursing act (a) in the observation, assessment, intervention, evaluation, rehabilitation, care

and counsel and health teachings of persons who are ill, injured or infirm or experiencing changes in normal health processes; (b) in the maintenance of health or prevention of illness; (c) in the administration of medications or treatments as prescribed by a licensed physician or dentist; (d) in the supervision or teaching of nursing; (e) in the administration, supervision, and evaluation of nursing practices, policies, and procedures. The foregoing shall not be deemed to include acts of medical diagnosis or prescription of therapeutic or corrective measures.

Open Records Act

Section BB-21.0

Tex. Rev. Civ. Stat. Ann., Art 6252-17a, §14 (Vernon Supp. 1982). See *Texas School Law Bulletin* 1982, TEA Pub. AD1 013 01.

§14. Interpretation of this Act

(a) This Act does not prohibit any governmental body from voluntarily making part or all of its records available to the public, unless expressly prohibited by law; provided that such records shall then be available to any person.

(b) This Act does not authorize the withholding of information or limit the availability of public records to the public, except as expressly so provided.

(c) This Act does not give authority to withhold information from individual members or committees of the Legislature of the State of Texas to use for legislative purposes.

(d) This Act shall be liberally construed in favor of the granting of any request for information.

(e) Nothing in this Act shall be construed to require the release of information contained in education records of any educational agency or institution except in conformity with the provisions of the Family Educational Rights and Privacy Act of 1974, as enacted by Section 513 of Public Law 93-380, codified as Title 20 U.S.C.A. Section 1232g, as amended.

Control and Eradication of Pediculosis in Minors Section BB-22.0

Tex. Rev. Civ. Stat. Ann., Art 4447k, §§1, 2 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§1.

The State Department of Health shall establish and develop a state program for the control and eradication of pediculosis of a minor. This program may include procedures for detection and instructions for treatment of same.

§2.

A parent or guardian of a minor who has been found to have pediculosis shall follow the instructions of the State Department of Health or shall place the minor under the care of a licensed physician for the purpose of treating the infestation of pediculosis of a minor.

Pilot Programs for Physical Evaluations of School Children Section BB-23.0

Tex. Educ. Code Ann. §11.20 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA AD1 013 01.

§11.20

(a) The Central Education Agency shall plan, institute, and supervise pilot programs in various school districts of this state for the purpose of screening children for health defects or problems.

(b) In each district selected for a pilot program, children shall be examined or evaluated in the manner prescribed by the Central Education Agency and by nurses or other allied health personnel specifically authorized to do so by the agency.

(c) Prior notice of the examination shall be given to the parents or guardian of each child, and no child shall be examined or evaluated if his parents or guardian object because of religious convictions.

(d) Whenever an abnormal health condition or problem is found in any child, the school nurse shall:

- (1) advise the child's parent or guardian;
- (2) suggest what action should be taken;
- (3) if necessary, assist the family in obtaining ac-

cess to appropriate health, rehabilitation, or treatment services; and

(4) review the case as necessary to determine that corrective action is taken to the extent possible.

(e) The agency shall require a record to be kept of each examination and actions taken pursuant to each examination. The record shall be confidential and shall be kept separate from the other records of the child. The records may be used for statistical purposes as long as the identity of each child is kept confidential.

(f) The agency shall require periodic reports from each district participating in the program for the purpose of evaluating the results of the program. The agency shall report its findings and recommendations to the legislature biennially during the first month of the regular session.

(g) The legislature shall appropriate money to finance the cost of the program, including planning, compensation for personal services, and necessary equipment and supplies.

Duties of Public School Principals

Section BB-24.0

Tex. Educ. Code Ann. §21.913 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.913

(a) Public school principals, who shall hold valid administrative certificates, shall be responsible for:

(1) assuming administrative responsibility and instructional leadership, under the supervision of the superintendent, for discipline, and the planning, operation, supervision, and evaluation of the educational program of the membership area in which he is assigned;

(2) submitting recommendations to the superintendent concerning assignment, evaluation, promotion and dismissal of all personnel assigned to the membership center; and

(3) performing any other duties assigned by the superintendent pursuant to school board policy.

(b) Nothing herein shall be construed as a limitation on the powers, responsibilities, and obligations of the school board as now prescribed by law.

Quarantine and Disinfection

Section BB-25.0

Tex. Rev. Civ. Stat. Ann., Art. 4477, Rules 15, 16, 26-30 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

Rule 15. Quarantinable for School Purposes.

Persons suffering from measles, whooping cough, mumps, German measles (rubella) and chicken pox, shall be required to be barred from school for twenty-one days (at the discretion of the local health officer) from date of onset of the disease, with such additional time as may be deemed necessary; and may be readmitted on a certificate by him attesting to their recovery and non-infectiousness.

Rule 16. Minor Diseases to be Excluded During Illness.

Those actually suffering from tonsillitis, scabies (itch), impetigo contagiosa, favus, shall be excluded from school during such illness and be readmitted on the certificate of the attending physician attesting to their recovery and non-infectiousness.

Rule 26. Persons Excluded From Schools.

Persons afflicted with trachoma, granulated lids, or contagious catarrhal conjunctivitis must be excluded from schools, public assemblages, and from close association with other individuals, unless they are under the constant care and strict supervision of a competent physician, and hold a certificate from said physician stating that active inflammation has subsided, said certificate to be countersigned by a local health authority.

Rule 27. Schools Temporarily Closed.

A schoolhouse wherein a child suffering from smallpox, scarlet fever or diphtheria has been present, shall be deemed infected and must be temporarily closed and thoroughly disinfected and cleaned under the supervision of the local health authority before reopening of the school.

Rule 28. School to Open After Disinfection.

In the event of the aforementioned disease being smallpox and in the case the Board of Trustees having passed a regulation requiring a successful vaccination of all teachers and pupils, the school may be reopened immediately after the disinfection and cleaning, and all teachers and pupils who have been successfully vaccinated may return; otherwise the school shall be kept closed eighteen days or until the local health authority directs otherwise.

Rule 29. To Notify Superintendents of Pupils From Infected Houses.

The local health authority shall notify the superintendent or principal of any school of the location of quarantinable diseases, and if the superintendent or principal finds any attendants in such school who live in said houses, he shall deny them admission to the said schools, only admitting them again upon presenting a certificate from the attending physician, countersigned by the local health authority, that there is no longer danger from contagion.

Rule 30. Children with Diseases Shall Not Attend School.

No superintendent, principal or teacher of any school, and no parent, master or guardian of any child or minor, having the power and authority to prevent, shall permit any child or minor, having any quarantinable disease, or any child residing in any house in which any such disease exists or has recently existed, to attend any public, private, parochial, church, or Sunday school until the requirements of these rules have been complied with.

Rights, Privileges, and Obligations of 18-Year-Olds Section BB-26.0

Tex. Rev. Civ. Stat. Ann., Art. 5923b, §§1-2 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§1.

The purpose of this Act is to extend all the rights, privileges, and obligations of majority to all persons who are at least 18 years of age. It shall be construed liberally to accomplish that purpose.

§2.

Notwithstanding any statutory or decisional law, or any rule, regulation, or ordinance of this state or of any political subdivision or incorporated city or town of this state, a person who is at least 18 years of age has all the rights, privileges, and obligations of a person who is 21

years of age. A law, rule, regulation, or ordinance which extends a right, privilege, or obligation to a person on the basis of a minimum age of 21, 20, or 19 years shall be interpreted as prescribing a minimum age of 18 years.

It is specifically provided, however, that with respect to property held by a custodian under the Texas Uniform Gifts to Minors Act, as amended (Article 5923-101, Vernon's Texas Civil Statutes), on effective date hereof and the proceeds and reinvestments thereof, the custodian may elect not to have the provisions of this Act apply by so notifying the minor in writing, but such election may be revoked at the election of the custodian.

Sanitation and Health Protection

Section BB-27.0

Tex. Rev. Civ. Stat. Ann., Art. 4477-1, §§6, 8, 16 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§6. Toilet Facilities

All operators, managers, or superintendents of any public buildings, school houses, theaters, filling stations, tourist courts, bus stations and taverns shall provide and maintain sanitary toilet accommodations.

§8. Public Buildings

Any and all public buildings hereafter constructed shall have incorporated therein all such heating, ventilation, plumbing, screening, and ratproofing features as may be necessary to properly protect the health and safety of the public.

§16. School Houses and Grounds

(a) Every school building shall be located on grounds that are well drained and maintained in a sanitary condition.

(b) Every school building shall be properly ventilated and provided with an adequate supply of drinking water and approved sewage disposal system, hand-washing facilities, a heating system, and lighting facilities, all of which shall conform with established standards of good public health engineering practices.

(c) All public school lunch rooms maintained and operated shall comply with the State Food and Drug Regulations.

(d) All public school buildings and appurtenances thereto shall be maintained in a sanitary manner.

(e) All building custodians and janitors employed on a full-time basis shall be versed in the fundamentals of safety and school sanitation.

**Comprehensive Special Education Program
For Handicapped Children**

Section BB-28.0

Tex. Educ. Code Ann. §16.104 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§16.104.

(a) The commissioner of education, with the approval of the State Board of Education, shall develop, and modify as necessary, a statewide design for the delivery of services to handicapped children in Texas which includes rules for the administration and funding of the special education program so that a free appropriate public education is available to all handicapped children between the ages of three and 21 by no later than September 1, 1980. The statewide design shall include, but may not be limited to, the provision of services primarily through local school districts and special education cooperatives, supplemented by a regional delivery structure. The commissioner shall further develop and implement a statewide plan with programmatic content which includes procedures designed to:

(1) ensure state compliance with requirements for supplemental federal funding for all state-administered programs involving the delivery of instructional or related services to handicapped students as defined in this section;

(2) facilitate interagency coordination when state agencies other than the Central Education Agency are involved in the delivery of instructional or related services to handicapped students;

(3) assess statewide personnel needs in all areas of specialization related to special education on a periodic basis and pursue strategies to meet those needs through

a consortium of representatives from regional education service centers, local education agencies, and institutions of higher education and through other available alternatives;

(4) ensure that regional education service centers throughout the state maintain a regional support function, which may include direct service delivery and a component designed to facilitate the placement of handicapped students who cannot be appropriately served within their resident districts;

(5) allow the Central Education Agency to effectively monitor and periodically conduct site visits of all local districts to ensure that agency rules adopted under this section are applied in a consistent and uniform manner, to ensure that districts are complying with those rules, and to ensure that annual statistical reports filed by the districts are accurate and complete;

(6) ensure the availability of sequentially related, field-based, inservice special education training programs for regular and special educators serving handicapped students and further ensure that all local districts dedicate at least the equivalent of one full day of their required inservice program per school year to that special education inservice training for those personnel;

(7) ensure that appropriately trained personnel are involved in the diagnostic and evaluation procedures

operating in all local districts and that those personnel routinely serve on local district admissions, review, and dismissal teams;

(8) ensure that an individualized education plan for each handicapped student is properly developed, implemented, and maintained in the least restrictive environment which is appropriate to meet the student's educational needs;

(9) ensure that, when appropriate, each handicapped student is provided an opportunity to participate in vocational and physical education classes, in addition to participation in regular or special classes; and

(10) ensure that each handicapped student is provided necessary related services.

(b) As used in this section:

(1) "Special services" means:

(A) "special teaching," which may be provided by professional and paraprofessional personnel in the following instructional settings:

(i) resource room;

(ii) self-contained classroom, regular or special campus;

(iii) hospital or community class;

(iv) homebound or bedside;

(v) speech or hearing therapy class; or

(B) "related services," which are developmental, corrective, supportive, or evaluative services, not instructional in nature, that may be required for the proper development and implementation of a handicapped student's individualized educational plan, including but not limited to special transportation, school health services, counseling with students or families, psychological services, audiological services, visual training, medical or psychiatric diagnostic services, occupational therapy, physical therapy, recreational therapy, social work services, parent counseling and training, adaptive equipment, special seating, orientation and mobility training, speech therapy, music therapy, and corrective therapy.

(2) "Resident district" means the local school district in which the parent or other person who has the primary legal obligation for care, control, and custody of a handicapped student resides, except that if the state is managing conservator of the student, the resident district is the district within which the student is placed by the state.

(c) The commissioner, with the approval of the State Board of Education, shall develop specific eligibility criteria based on the general classifications established by this section with reference to contemporary diagnostic or evaluative terminologies and techniques. Eligible handicapped students shall enjoy the right to a free appropriate public education, which may include instruction in the regular classroom, instruction through special teaching, or instruction through contracts approved under this section. Instruction shall be supplemented by the provision of related services when appropriate. The following classifica-

tions of handicapped students shall serve as the general eligibility criteria for participation in a district's special education program:

(1) "Handicapped students" means students between the ages of 3 and 21, inclusive;

(A) with educational handicaps (physically handicapped, auditorially handicapped, visually handicapped, mentally retarded, emotionally disturbed, learning disabled, speech handicapped, autistic, or multiply handicapped); and children leaving and not attending public school for a time because of pregnancy; and

(B) whose disabilities are so limiting as to require the provision of special services in place of or in addition to instruction in the regular classroom.

(2) "Physically handicapped students" means students whose body functions or members are so impaired from any cause that they cannot be adequately or safely educated in the regular classes of the public schools without the provision of special services.

(3) "Auditorially handicapped students" means students whose hearing is so impaired that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

(4) "Visually handicapped students" means students whose sight is so impaired that they cannot be adequately or safely educated in the regular classes of the public schools without the provision of special services.

(5) "Mentally retarded students" means students with significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior and manifested during the developmental period such that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

(6) "Emotionally disturbed students" means students whose emotional condition is psychologically or psychiatrically determined to be such that they cannot be adequately and safely educated in the regular classes of the public schools without the provision of special services.

(7) "Learning disabled students" means students:

(A) who demonstrate a significant discrepancy between academic achievement and intellectual abilities in one or more of the areas of oral expression, listening comprehension, written expression, basic reading skills, reading comprehension, mathematics calculation, mathematics reasoning, or spelling;

(B) for whom it is determined that the discrepancy is not primarily the result of visual handicap, hearing impairment, mental retardation, emotional disturbance, or environmental, cultural, or economic disadvantage; and

(C) for whom the inherent disability exists to a degree such that they cannot be adequately served in the regular classes of the public schools without the provision of special services.

(8) "Speech handicapped students" means students whose speech is so impaired that they cannot be adequately educated in regular classes of the public schools without the provision of special services.

(9) "Autistic students" means students whose disturbances of speech and language, relatedness, perception, developmental rate, and motility are such that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

(10) "Multiply handicapped students" means students handicapped by any two or more of the handicapping conditions described in Subdivisions (2) through (9) of this subsection that may result in multisensory or motor deficiencies and developmental lags in the cognitive, affective, or psychomotor areas such that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

Student Services

Section BB-29.0

19 Tex. Admin. Code §85.1 (McGraw-Hill 1981).

§85.1. Scope

(a) As part of the public education program, student services shall include guidance services, student health services, and attendance services (§97.96 (5) (226.37.15.250) of this title (relating to Principle 5)).

(b) Student services may also include home/school coordination, school psychological services, school lunch and child nutrition services, and transportation. Note: Cer-

tain school districts are required to participate in the national school breakfast program in accordance with Texas Education Code §21.914.

(c) Districts which provide services listed in subsection (b) of this section shall comply with relevant law and State Board of Education policies and their corresponding administrative procedures.

Tuberculosis, Examining Public School Personnel

Section BB-30.0

25 Tex. Admin. Code §§97.91-97.97 (McGraw-Hill 1981).

§97.91. Categories of Employees and Volunteers

The following categories of employees and volunteers in Texas public schools are subject to examination, provided that the accumulated time of employment or volunteer service in the school is expected to be more than 90 hours for each school year by each such employee or volunteer: teachers, teachers aides and other classroom personnel, coaches and trainers, bus drivers, librarians, nursing and health personnel, supervisory personnel, clerical personnel, counselors, foodhandlers, persons performing custodial duties or janitorial duties.

§97.92. Certificate of Examination

The form and content of the certificate of examination shall be substantially as illustrated below, provided that another form may be used if all the elements of the standard form are embodied in it. A certificate issued on or after April 15, 1978, but before the effective date of this section shall be valid if it embodies the information contained in the standard form and is signed by a physician licensed to practice medicine in Texas.

§97.93. Closing Date for Filing Certificate

The closing date for filing of individual certificates with the governing body of the Texas public school shall

be the date on which the individual is to commence duties at the school; those duties shall not commence until the certificate has actually been received by the governing board or its authorized representatives.

§97.94. Transfer of Certificate Between School Districts

An original or true and correct copy of a certificate shall be honored by the governing body of school on transfer of an employee or volunteer from another Texas public school provided that the certificate is complete and valid and further provided that not more than 120 days will have elapsed in employment in a Texas public school.

§97.95. Expiration and Frequency of Certificates

A certificate shall expire and a new certificate shall be required if more than 120 days shall have elapsed since employment or volunteer service in a Texas public school.

§97.96. Reexaminations

An employee or volunteer shall be required to produce a new certificate of examination within 30 days of notification of the governing board by the local health authority or the Texas Department of Health that the individual has been exposed to a reported case of tuberculosis

or has had probable exposure to a case of tuberculosis, regardless of whether the actual identity of the case has been determined or not.

§97.97. Reporting Results of Examination

The results of the examinations and reexaminations shall be reported to the Texas Department of Health Bureau of Tuberculosis Services by the governing body of

each school, over signature of the superintendent of the school, not later than 30 days after the start of each school year. The results shall be reported on a standard form developed and revised as deemed necessary by the Texas Department of Health, with such copies as the department may deem necessary. The initial version of this form is illustrated below (Form No. TB-5) and may be reproduced locally if desired.

Prevention, Eradication, and Control of Tuberculosis Section BB-31.0

Tex. Rev. Civ. Stat. Ann., Art. 4477-12, §§4, 5 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§4. Examination of Pupils for Tuberculosis Infection.

The Texas Board of Health Resources may provide for the examination for tuberculosis infection of pupils in the first and seventh grades of the public, parochial and private schools of this state, and of pupils transferred to public, parochial and private schools of this state from another state or country.

§5. Certificate of Examination of School Personnel

(a) The governing body of each public school within the State shall require that each individual who is employed by or who acts as a volunteer for the governing body, and who is included within certain categories designated by the Texas Board of Health, shall present to the governing body a certificate, signed by a physician licensed to practice medicine in Texas, which states that the individual has been examined for tuberculosis and discloses the results of the examination. The governing body of each public school shall verify that each individual within its jurisdiction who is included within this Act, has the required certificate and shall not permit any individual to commence his or her duties in the absence of the certificate. The Texas Board of Health may require reexamination of any individual employee or volunteer as the Board determines is necessary and appropriate to protect the public health.

(b) The Texas Board of Health shall adopt rules describing the following:

- (1) the designation of the categories of employees or volunteers who are required to be examined;
- (2) the form and content of the required examination certificate;
- (3) the closing dates for filing such individual certificates;
- (4) the transfer of such individual certificates between public school districts;
- (5) the frequency of such required examinations;
- (6) the criteria for requiring reexaminations; and
- (7) the reporting of the results of such examinations to the Texas Department of Health.

(c) This section and the rules adopted by the Texas Board of Health by the authority of this Act, shall be the minimum acceptable standards for the examination of the named categories of individuals for tuberculosis. A school district may adopt and enforce more stringent standards, except that the requirements for a tuberculosis examination may not include exposure of X-rays unless the person being examined consents or the examining physician determines that the X-ray examination is medically necessary and states that determination on the required certificate.

Children's Vision Screening Act of 1979

Section BB-32.0

Tex. Rev. Civ. Stat. Ann., Art. 4419F, (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§ 1. Short Title

This Act shall be known as and may be cited as "The Texas Children's Vision Screening Act of 1979."

§2. Purpose

The purpose of children's vision screening is to identify those children who need a thorough eye examination by a professional eye examiner. Such screening is particularly necessary in early childhood since many visual

defects will become incurable if detected too late. Screening is not a diagnostic procedure and decisions about the need for treatment can only be made after a professional eye examination. Besides discovering vision defects which may interfere with the child's education, vision screening helps the teacher prepare assessments of the child's educational potential and helps to detect those children who are needing special educational services because of insufficient vision. It shall not be the intent of the legislature to im-

pose any added fiscal implications or additional costs on units of local government.

§3. Definitions

(a) "Board" means the Texas Board of Health.

(b) "Department" means the Texas Department of Health.

(c) "Vision screening" means a test or battery of tests for rapid determination of the need for a more complete visual examination by an eye specialist.

§4. Children's Vision Screening Required; Exception

(a) It is required for all children enrolling in any public, private, parochial, or denominational school in Texas for the first time, that the parent, managing conservator, or other person having a legal responsibility for the child's support shall submit to the admitting officer of the school within 90 days after admission a certificate which states that the child has either (1) been examined by a physician licensed to practice in the United States or an optometrist licensed to practice in the United States or (2) undergone a vision screening test which has been approved by the board and which discloses the results of the examination or test.

(b) Subject to the exception in Subsection (c) of this section, the board may by rule modify the requirement of Subsection (a) to require the additional periodic examination or screening of children it determines is necessary.

(c) A child may be provisionally admitted to a kindergarten, elementary, or secondary school upon the submission of an affidavit signed by the parent, managing conservator, or person having a legal responsibility for the child's support, that the child will undergo the required vision screening test or examination as rapidly as is feasible.

(d) The requirements of this section are mandatory except in the event that the affected child's parent, managing conservator, or person having a legal responsibility for the child's support presents to the school authorities an affidavit signed by the parent, managing conservator, or person having a legal responsibility for the child's support stating that the visual screening test conflicts with the tenets or practices of a recognized church or religious denomination of which the affiant is an adherent or a member.

(e) The governing body of each school shall ensure that all parents, managing conservators, or persons having a legal responsibility for the support of school children within the jurisdiction of the governing body present the required certificate of examination or screening, or an affidavit of exemption based on religious tenet or practice.

§5. Required Certificate.

(a) The certificate required shall be in a form prescribed by the board and shall contain that information

which may be required by the board to carry out the intent of this Act.

(b) The certificate may be signed by:

(1) a physician licensed to practice in the State of Texas or an optometrist licensed to practice in the United States who performed the eye examination;

(2) a physician licensed to practice in the State of Texas or an optometrist licensed to practice in the United States who personally supervised a vision screening test; or

(3) health personnel, volunteers, school nurses or aides, or other school personnel who have undergone a special training program in the administration of children's vision screening testing which meets the standards approved by the board.

(c) The requirement of Section 4 may be met by an entry made in the official school record of the child which states that the child has undergone a vision screening test which meets the standards set by the board, that the test was administered by a person authorized in this section to sign the required certificate, and which discloses the results of the test.

§6. Examination or Test Records; Reporting

(a) Each school covered by this Act shall keep an individual eye examination or vision screening record for each student during the period of attendance for each child admitted, and the records shall be open for inspection at all reasonable times by representatives of the local health departments or the Texas Department of Health.

(b) Each school covered by this Act shall cooperate in transferring student's eye examination or vision screening records between other schools. Specific approval from the parent, managing conservator, or other person having a legal responsibility for the child's support is not required prior to making such transfers.

(c) The department shall develop the form for a required annual report of the results of the examinations or tests and the report will be submitted according to the instructions of the board.

§7. Powers of the Texas Board of Health

(a) The board is authorized to establish a vision screening program in the department.

(b) The board, in consultation with the advisory committee, shall adopt rules to carry out the intent of this Act. These rules shall include, but not be limited to, rules prescribing the following:

(1) form and content of the required certificate;

(2) the closing dates for presenting such certificates;

(3) transfer of individual certificates between schools;

(4) criteria for rescreening and referral;

(5) reporting of results and referrals to the department;

(6) standards required for vision screening tests and screener training courses to ensure excellence and uniformity in the vision screening program.

(c) The board acting through the department and in consultation with the advisory committee shall:

(1) train or approve the training of persons who will administer vision screening tests;

(2) monitor the quality of screening activities in an appropriate manner;

(3) directly or through local health departments or regional public health offices, assist school districts and other organizations in developing programs to provide vision screening for children;

(4) compile and publish statistical analyses of reports relating to examination and screening results and referrals to ascertain the impact of the requirements on public health.

§8. Advisory Committee on Vision Screening

The board shall appoint an advisory committee on children's vision to consult with and advise the board in determining acceptable technical and professional standards which must be met by any individual or public or private health care entity undertaking to perform the vision screening tests allowed in Section 4 of this Act. The advisory committee will also advise the board on referral and appropriate follow-up.

(a) The advisory committee shall be composed of:

(1) two physicians who are licensed to practice in Texas and whose medical specialty is ophthalmology;

(2) two optometrists who are licensed to practice in Texas, one of whom must be a member of the Texas Optometric Association and one of whom must be a member of the Texas Association of Optometrists; and

(3) two persons to represent the public who have experience in and an interest in children's visual problems.

(b) Except for those first appointed, members are appointed for terms of six years expiring on August 31 of the odd-numbered years. If a vacancy occurs on the committee, the board shall appoint a member to serve the unexpired portion of the term.

(c) The advisory committee shall serve without compensation; however, the committee members may be reimbursed for their actual and necessary expenses incurred while fulfilling their duties as committee members.

(d) The advisory committee, after approval from the department, may from time to time invite the participation of representatives of professional and volunteer organizations in their activities.

§9. Interagency Committee on Children's Vision

(a) The functioning of the vision screening program shall be assisted by an interagency committee on children's vision. The commissioner of education, the commissioner of human resources, the executive director of the State Commission for the Blind, and the commissioner of health shall appoint one member from their agency to the committee. The committee members shall coordinate preschool and school vision screening programs and the vision health programs in their respective agencies in the State of Texas. The committee may invite the advisory committee on children's vision, authorized under this Act, to meet with it and to offer professional consultation when requested.

(b) The interagency committee shall select one of its members as chairman and may elect other officers that it considers necessary. The committee may meet as often and at any place that it may decide, but shall meet at least once in each calendar year.

§10. Limitation on Authority

Nothing in this Act shall be construed as giving anyone authority to require the maintenance of any forms or filing of reports that were not required prior to the passage of this Act.

§11. Initial Appointments

In making the initial appointments to the advisory committee, the board shall appoint one ophthalmologist and one optometrist for terms expiring on August 31, 1981; one optometrist and a person representing the public for terms expiring August 31, 1983; and one ophthalmologist and a person representing the public for terms expiring August 31, 1985.

Education for the Visually Handicapped

Section BB-33.0

Tex. Educ. Code Ann. §11.052 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§11.052.

(a) The Central Education Agency shall develop and administer a comprehensive statewide plan for the education of visually handicapped children under 21 years of age which will ensure that the children have an opportunity for achievement equal to the opportunities afforded their peers with normal vision.

(b) The Central Education Agency shall be responsible for:

(1) the development of standards and guidelines for all special education services for the visually handicapped which it is authorized to provide or support pursuant to the provisions of this code, including matters related to standards and accreditation;

(2) the supervision of such field offices as might from time to time be established to assist local school districts in serving visually handicapped children more effectively;

(3) the development and administration of special programs for children handicapped by both serious visual loss and serious hearing loss;

(4) the evaluation of special education services provided for visually handicapped children by local school districts and the approval or disapproval of state funding of such services; and

(5) the maintenance of effective liaison between special education programs provided for the visually handicapped by local school districts and related initiatives exerted by the State Commission for the Blind, the Department of Mental Health and Mental Retardation, the School for the Blind, and other related programs, agencies, or facilities as appropriate.

Vocational Nurse Act

Section BB-34.0

Tex. Rev. Civ. Stat. Ann., Art. 4528c, §6(a) (Vernon Supp. 1982)

§ 6. Examination and Licenses

(a) Except as provided in Section 7 of this Act, every person desiring to be licensed as a Licensed Vocational Nurse or use the abbreviation L.V.N. in the State of Texas, shall be required to pass the examination given by the Board of Vocational Nurse Examiners or its delegate. The applicant shall make application by presenting to the secretary of the Board, on forms furnished by the Board,

satisfactory sworn evidence that the applicant has had at least two (2) years of high school education or its equivalent and has completed an approved course of not less than twelve (12) months in an approved school for educating vocational nurses. An approved school as used herein shall mean one approved by the Board. Application for examination by the Board or its delegate shall be made at least thirty (30) days prior to the date set for the examination.

Medical Practice Act of Texas

Section BB-35.0

Tex. Rev. Civ. Stat. Ann., Art. 4495b, §3.06(d) (1), (2), (3), (4), (Vernon Supp. 1982).

§3.06. Definitions

(d) This Act shall be so construed that:

(1) a person licensed to practice medicine shall have the authority to delegate to any qualified and properly trained person or persons acting under the physician's supervision any medical act which a reasonable and prudent physician would find is within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician, the act can be properly and safely performed by the person to whom the medical act is delegated and the act is performed in its customary manner, not in violation of any other statute, and the person does not hold himself out to the public as being authorized to practice medicine. The delegating physician shall remain responsible for the medical acts of the person performing the delegated medical acts. The board may determine whether or not an act constitutes the practice of medicine, not inconsistent with this Act, and may determine whether any medical act may or may not be properly or safely delegated by physicians;

(2) a person licensed to practice medicine is authorized and shall have the authority to delegate to any

qualified and properly trained person or persons, acting under the physician's supervision, the act or acts of administering or providing, in the physician's office, dangerous drugs, as ordered by the physician which are used or required to meet the immediate needs of the physician's patients. The administration or provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders, where applicable, as the orders are defined by the board. The administration or provision of dangerous drugs shall be in compliance with laws relating to the practice of medicine and Texas and federal laws relating to the dangerous drugs. This subdivision does not permit the physician or person or persons acting under the supervision of the physician to keep a pharmacy, advertised or otherwise, for the retailing of the dangerous drugs without complying with the applicable laws relating to the dangerous drugs;

(3) a person licensed to practice medicine shall be authorized and shall have the authority to delegate to any qualified and properly trained person or persons, acting under the physician's supervision, the act or acts of ad-

ministering or providing dangerous drugs, if the provision is provided through a facility licensed by the State Board of Pharmacy pursuant to applicable law, as ordered by the physician, which are used or required, to meet the immediate needs of the physician's patients. The administration or provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders, where applicable, as the orders are defined by the board. The provision of dangerous drugs shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, Texas or federal drug laws, and rules that may be properly issued by the State Board of Pharmacy. The administration shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, and Texas or federal drug laws. This subdivision does not permit the physician or person or persons acting under the supervision of the physician to keep a pharmacy, advertised or otherwise, for the retailing of the dangerous drugs without complying with the applicable laws relating to the retailing of dangerous drugs. In this subdivision and in Subdivision (2) of this subsection, 'administering' means the direct application of a drug by injection, inhalation, ingestion, or any other means to the body of the physician's patient; 'provision' means to supply one or more unit doses of a drug, medicine, or dangerous drug. The drug or medicine shall be supplied in a suitable container that has been labeled in compliance with the applicable drug laws. However, a qualified and trained person or persons, acting under the supervision of a physician, may be permitted to specify at the time of the provision the inclusion of the date of provision and the patient's name and address;

(4) in the provision of services and the administration of therapy by public health departments, as officially prescribed by the Texas Department of Health for the prevention or treatment of specific communicable diseases or health conditions for which the Texas Department of Health is responsible for control under state law, a person licensed to practice medicine shall be authorized and shall have the authority to delegate to any qualified and properly trained person or persons, acting under the physician's supervision, the act or acts of administering or providing dangerous drugs, as ordered by the physician that are used or required to meet the needs of the patients. The administration of provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders where applicable, as the orders are defined by the board. The provision of dangerous drugs shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of pharmacy, and laws relating to the practice of professional nursing. The orders may not be inconsistent with this Act and may not be used for the performance of acts and duties that require the exercise of independent medical judgment. In this subdivision, 'administering' means the direct application of a drug by injection, inhalation, ingestion, or any other means to the body of the patient; 'provision' means to supply one or more unit doses of a drug, medicine, or dangerous drug. The drug or medicine shall be supplied in a suitable container that has been labeled in compliance with the applicable drug laws. However, a qualified and trained person or persons, acting under the supervision of a physician, may be permitted to specify at the time of the provision the inclusion of the date of provision and the patient's name and address.

Texas Pharmacy Act

Section BB-36.0

Vernon Ann. Civil Stat., Art. 4542A-1 §§5(2)(a)(b), (8), (12)(a)(b), (34), 29(a), (b), (c)(4), (g) and 33(b).

§5. Definitions

In this Act, unless the context of its use clearly indicates otherwise:

(2) "Administer" means the direct application of a prescription drug by injection, inhalation, ingestion, or any other means to the body of a patient by:

(A) a practitioner or an authorized agent under his supervision; or

(B) the patient at the direction of a practitioner.

(8) "Class D pharmacy license" or "clinic pharmacy license" means a license issued to a pharmacy dispensing a limited type of drugs or devices pursuant to a prescription drug order.

(12) "Dangerous drug" means any drug or device that is not included in Penalty Groups 1-4 of the Controlled Substances Act and that is unsafe for self-medication or any drug or device that bears or is required to bear the legend:

(A) "Caution: federal law prohibits dispensing without prescription"; or

(B) "Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian."

(34) "Provide" means to supply one or more unit doses of a nonprescription drug or dangerous drug to a patient.

§29. Registration of Pharmacies

- (a) A pharmacy shall annually register with the board.
- (b) Each pharmacy shall apply for a license in one or more of the following classifications:
 - (1) Class A;
 - (2) Class B;
 - (3) Class C; or
 - (4) Class D.
- (c) Each pharmacy shall be under the supervision of a pharmacist as follows:
 - (4) a Class D pharmacy shall be under the continuous supervision of a pharmacist whose services shall be required according to the needs of the pharmacy.
- (g) A pharmacy operated by the state or a local government that qualified for a Class D license may not be required to pay a fee to obtain a license.

§33. Administration and Provision of Dangerous Drugs

A person licensed to practice medicine shall have the authority to delegate to any qualified and properly trained person or persons, acting under such physician's supervision, the act or acts of administering or providing dangerous drugs, if such provision is provided through a facility licensed by the board pursuant to Section 29(b)(4) of this Act, as ordered by such physician, that are used or required to meet the needs of such physician's patients.

Such administration or provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders, where applicable, as such orders are defined by the Texas State Board of Medical Examiners. Such provision of dangerous drugs shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, Texas or federal drug laws, and rules that may be properly issued by the board. Such administration shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, and Texas or federal drug laws. Nothing in this section shall permit the physician or person or persons acting under the supervision of such physician to keep a pharmacy, advertised or otherwise, for the retailing of such dangerous drugs without complying with applicable laws relating to same. Such dangerous drug shall be supplied in a suitable container that has been labeled in compliance with applicable drug laws; provided, however, a qualified and trained person or persons acting under the supervision of a physician may be permitted to specify at the time of such provision the inclusion of the date of provision and the patient's name and address.

Section CC

Sample Forms

Section CC	Sample Forms
	1.0 Daily Report Form
	2.0 School Nursing Summary Sheet
	3.0 Permanent Cumulative Health Record
	4.0 Student Emergency Card
	5.0 Accident Report
	6.0 Head Injury Sheet
	7.0 Animal Bite Record
	8.0 Letter to Parent
	9.0 Daily Log for Medication
	10.0 Physician's Authorization for Special Health Care
	11.0 Specialized Physical Health Care Service: Daily Log
	12.0 Certificate of Examination, Tuberculosis
	13.0 Student Transfer Record

School Health Program Reports

A statistical report is a means of assuring accountability in the school health program. Reporting with statistical data is helpful in revealing work loads, accomplishments, and perhaps deficits.

Many principals, superintendents, and school boards will appreciate a periodic report on the school health program activities. Nurse administrators may wish to include a narrative report along with the statistical data. Narratives in which a particular school nurse has made a special effort to assist an individual student or group are beneficial. A narrative report may also project goals and objectives for future health service programs.

School Nursing Summary Sheet



Section CC-2.0

 Dates Covered: _____
 (6 Week Reporting Period)

No. Nurse Extenders: _____

School: _____

Total Visits to School: _____

Enrollment: _____

Average Hours per Visit: _____

I. Health Supervision	No. Pupils	No. Ref.	Referrals Completed		
			Valid Ref.	Rec'd. Tx.	Over Ref.
Physical Assessment					
Health Counseling					
Major Illness					
Minor Illness					
Emergency					
First Aid					
Emotional					
Meds. Supervision					
Special Procedure					
Child Abuse					
Comm. Disease					
Other					
II. Screening					
Vision					
Hearing					
Weight & Height					
Scalp & Skin					
Blood Pressure					
Dental					
Scoliosis					
Reportable Disease					
TB Skin Test					
Other					
III. Health Activities	Students	Classes	Parents	Staff	Community
Health Teaching					
Health Conference					
IV. Staff Development	No.	Hrs. Req.	Other Activities:		
Orientation, self/others					
Supervision					
Class Prep. Time					
Staff Meetings					
Professional Mtgs.					
Professional Growth					
Inservice					
V. Others					
Home Visits					
Community Mtgs.					
School-Sponsored Mtgs.					
Field Trips-Sponsored					

Signature and Title

**Instruction for School Nursing Summary Sheet**

Section CC-2.0

DATES COVERED: One six week report should be completed for each school a nurse covers.

SCHOOL: Name of school, including whether it is elementary, intermediate, or high school.

ENROLLMENT: Total enrollment of school.

NUMBER OF NURSE EXTENDERS: Number of LVN, Aides, or volunteers.

TOTAL VISITS TO SCHOOL: Total number of visits made to the school by the nurse.

AVERAGE HOURS/VISIT: Average number of hours per visit to the school.

I. Health Supervision for Students

These figures will be a cumulative number taken from the daily reporting form and extended to examine those referrals made.

Physical Assessment: Under this category, physical assessment is an assessment of an entire system, i.e., neurological, cardiopulmonary, musculo-skeletal, or an entire physical examination.

Health Counseling: Health counseling may include such subjects as nutrition, cleanliness, crutch-walking, need to wear glasses, or referrals from staff of student problems.

Major Illness/Minor Illness: Whether or not to term an illness "major" or "minor" is subjective and will of necessity be a judgment decision by the nurse. Some examples may be of benefit: a stomachache versus a possible appendicitis; a headache versus a migraine headache; a 99° temperature versus a 102° temperature.

Emergency/First Aid: These categories will also have to be determined subjectively by the school nurse.

Emotional: Children, during stress or having emotional problems, will often seek out a neutral area such as a school clinic. Frequent "headache" or "stomachache" complaints or repeated absences of the same class should provide clues to the nurse that a child may be having other problems.

Medication: A notation in this area will provide inclusion of the child who comes into the clinic to take regular medication. A form showing the child's name, medication, and time should also be kept (sample provided).

Special Procedure: Procedures such as catheter care, catheterization, feeding, suctioning, ostomy care or stoma care should be noted in this category.

Child Abuse: Procedures for reporting and filing a report will be carried out as designated by law. Notation must be careful and complete. Aside from other reports, notation should be made here for cumulative reportings.

Communicable Disease: Communicable disease such as chicken pox, influenza or flu-like illness, or streptococcal sore throats should be noted in this category.

II. Screening

Screening procedures and reporting are self-explanatory. Reporting in a six week period will be of assistance in planning and evaluating of nurse-time.

III. Health Activities

Health Teaching and Health Conference are broken down into the number of contacts on individual and group basis.

IV. Staff Development

School nurses perform many time-consuming activities for which there is no method of reporting.

V. Other Activities

This section, though not staff development, is a job-related activity. It should include time spent during a day for the benefit of the school child.

Permanent Cumulative Health Record

Section CC-3.0

TAG FOR SPECIAL HEALTH CONDITION

NOTE: All Materials in Faded Ink.



Healthy Independent School District—Permanent Cumulative Health Record

Healthy, Texas

Parent Fill in Sections 1, 2, & 3 ONLY

1. Student's Name (Last) (First) (M.I.) Date of Birth M F

2. Parent's Name Address (in pencil) Phone

3. Student's Physical History:

Year		Year	GROWTH RECORD AND VISION																						
			Date																						
			Grade																						
			Age																						
			Height																						
			Weight																						
			Head Circumference																						
			Type of Test																						
			Without Correction	R	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/			
			L	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/			
			Both Eyes	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/			
			With Correction (Glasses or Contacts)	R	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/			
			L	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/	20/			
Accident—Serious			Neurological Disorder																						
Allergy—Drug/Other			Orthopedic Handicap																						
Asthma			Otitis Media																						
Blood Disorder			Rheumatic Fever																						
Cardiac Disease/Problem			Seizure Disorder																						
Congenital Deformity			Speech Disorder																						
Diabetes			Surgery—Serious																						
Hearing Loss			T.B. Contact																						
Hypertension			Ulcer																						
Illness—Serious			Urinary Problem																						
Kidney Disorder			Vision Loss																						
Muscular Disorder			Other																						
IMMUNIZATION RECORD			Physician Recommendations, Restrictions, Medications		HYPERTENSION SCREENING																				
			Reason	Dates	Date																				
Prevention Record			1st Dose Mo/Yr	2nd Dose Mo/Yr	3rd Dose Mo/Yr	Booster Mo/Yr	Booster Mo/Yr	R																	
								L																	
Diphtheria/Pertussis/Tetanus								Special Services: Recommendations, Reports, Program Adjustment																	
Tetanus/Diphtheria																									
Polio																									
Rubella (Vac. or Date/illness)																									
Rubella																									
Mumps (Vac. or Date/illness)																									
MMR																									
TB Test			*DENTAL SCREENING																						
			Date	Results	Referred	Corrected	Re-Clk																		
Chest X-Ray																									
Other																									
Verifying Physician/Clinic																									
Nurse/Signature																									
Medical/Religious Exemption:			*Codes																						

*C-Caries, G-Gingivitis, H-Hygiene, O-Orthodontic, O.K.-No problem

(Back of Form)

Section CC-3.0

TEACHER OBSERVATION										NAME			D.O.B.		NOTE: All Referrals in Red Ink.													
Use X when defect observed; circle X when corrected H.I.—Record health inventory in first TNC column															Audiometric Screening													
Teacher-Nurse Conference Date										Date			Referral and Follow-Up		Nurse		Sweep		AUDIOGRAM									
																	Data											
General	Tires easily																R	Norm	R	db								
	Under or overweight																L	Norm	L	db								
	Posture																R	Norm	R	db								
	Muscular coordination																L	Norm	L	db								
	Hair, Scalp, Skin																R	Norm	R	db								
	Personal hygiene																L	Norm	L	db								
Eyes	Eyeballs																R	Norm	R	db								
	Strabismus																L	Norm	L	db								
	Squint																R	Norm	R	db								
	Frequent headaches																L	Norm	L	db								
	Eyes water																R	Norm	R	db								
Ears	Discharge																L	Norm	L	db								
	Earaches																R	Norm	R	db								
	Does not hear well																L	Norm	L	db								
Nose	Freq. colds—nosebleeds																R	Norm	R	db								
Mouth	Mouth breathing																L	Norm	L	db								
Throat	Freq. sore throat																											
Teeth	Oral hygiene																											
	Obvious defects																											
	Gums																											
Behavior Pattern	Disturbs classroom																											
	Nervous/restless																											
	Twitching—fainting																											
	Nail biting																											
	Shy																											
	Over-aggressiveness																											
	Freq. stomachaches																											
	Excessive use of toilet																											
	Peer relations																											
Doesn't like school																												
Other	Food habits																											
	Speech Problem																											
	General Cleanliness																											
	Excessive Absence																											

P—Passed, Re-Ck, F—Failed, R—Referred

Student Emergency Card

Section CC-4.0



Student Emergency Card

Date _____

School _____

Grade _____

Birth Date _____

Student's Name _____

Last First Middle

Address _____ Home Telephone _____

City _____ Zip _____

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information for emergency calls:

Name _____

Business Address

Business Telephone

Mother _____

Father _____

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED:

Name _____ Name _____

Address _____ Tel _____ Address _____ Tel _____

HEALTH INFORMATION: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic condition, etc.

Explanation: _____

DOCTOR: 1st choice _____ 2nd choice _____

Telephone Number _____ Telephone Number _____

Telephone Number _____

HOSPITAL CHOICE: Address _____ Telephone Number _____

Telephone Number _____

****IMPORTANT—PLEASE COMPLETE REVERSE SIDE OF CARD****



Student Emergency Card

Section CC-4.0

(Back of Emergency Card)

I, the undersigned, do hereby authorize officials of _____
School District to contact directly the persons named on this card, and do authorize the named physicians to render such treatment
as may be deemed necessary in an emergency, for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized
to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent or Guardian

Student's Last Name

First

Initial

Accident Report



Section CC-5.0

To be filled in at the time of the accident by the person caring for an injured student who is referred to a doctor:

Student name _____ Phone _____

Address _____ Age _____ Sex _____

Date _____ Time _____ Insurance _____

Grade _____ Teacher _____ School _____

Location of accident _____

Person in attendance _____

Nature of Accident	
Abrasion	Head Injury
Bruise/Bump	Fracture
Burn	Laceration
Cut	Puncture
Convulsion	Shock
Dislocation	Sprain
Other _____	

Part of Body Injured		
Abdomen	Eye*	Head
Ankle*	Face	Knee*
Arm*	Finger*	Leg*
Back	Foot*	Teeth
Chest	Hand	Wrist*
Elbow*		
Other _____		

*Left, right, both		

How did it happen? _____

Were parents notified? Yes _____ No _____

Treatment and disposition: _____

 Follow-up: _____

Amount of time lost from school: _____

(Signature) _____

Principal, Teacher, or Nurse

**Head Injury Sheet**

Section CC-6.0

Dear Parent:

Today, _____ (Child's Name) _____ received an injury to the head. Your child was seen in the clinic and had no problems at that time, but you should watch for any of the following symptoms:

1. Severe headache.
2. Excessive drowsiness (awake the child at least twice during the night).
3. Nausea and/or vomiting.
4. Double vision, blurred vision, or pupils of different sizes.
5. Loss of muscle coordination such as falling down, walking strangely, or staggering.
6. Any unusual behavior such as being confused, breathing irregularly, or being dizzy.
7. Convulsion.
8. Bleeding or discharge from an ear.

CONTACT YOUR LOCAL DOCTOR OR EMERGENCY ROOM IF YOU NOTICE ANY OF THE ABOVE SYMPTOMS.

School Nurse

Telephone Number

Animal Bite Record



Section CC-7.0

Date of bite: _____ Time of bite: _____

Name of person involved: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Age: _____ Sex: _____

Breed/Type of animal with general description: _____

Age of animal: _____ Sex of animal: _____

Approximate weight of animal: _____

Date of vaccination: _____ City: _____

Description of incident (on school grounds? to/from school? animal confined, leashed/unleashed? etc.) _____

Area on person bitten: _____

Owner of animal: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Bite reported to: (LOCAL ANIMAL CONTROL AGENCY) _____

Time & Date reported: _____

Signature: _____



School Health Program Letter to Parent

Section CC-8.0

School _____ Date _____

Name of Child _____ Grade _____

Name of Teacher _____

Dear Parent:

In watching the health of your child, the teacher and I have noted the following observations which we feel should be brought to your attention:

Principal _____

Nurse _____

Phone _____

The school would appreciate comments from you or your doctor regarding these signs if you feel the information would be helpful for the nurse or teacher.

Date: _____

Parent's comments OR Doctor's diagnosis, treatment, and recommendations:

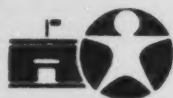
Parent's Signature _____

OR _____

Doctor's Signature _____

Daily Log for Medication

Section CC-9.0



Daily Log for Medication

School	Week of					Week of					Week of					Week of				
	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				

The person dispensing the medication signs his or her name in the block under the corresponding day of the week.



**Physician's Authorization
For Having Specialized Physical Health Care
Service Procedures Administered**

Section CC-10.0

Name of Student: _____ Birth Date _____

Address: _____

1. Physical condition for which the standardized procedure is to be performed: _____

2. Name of standardized procedure: _____

3. Precautions, possible untoward reactions, and interventions: _____

_____4. Time schedule and/or indication for the procedure: _____

5. The procedure is to be continued as above until: _____

(Date)

Physician's Signature_____
Date_____
Address_____
Telephone

I hereby request that the treatment specified above be performed to the above-named child.

Signature of Parent/Guardian_____
Date

Specialized Physical Health Care Service Daily Log of Treatment Administered

Section CC-11.0



Name: _____ Birth Date: _____

School: _____

Procedure: _____

From: _____, 19 _____ To: _____, 19 _____

Physician: _____ Phone: _____

Date	Time	Comment	Init.	Date	Time	Comment	Init.	Date	Time	Comment	Init.

Date	Time	Comment	Init.	Date	Time	Comment	Init.	Date	Time	Comment	Init.

Date	Time	Comment	Init.	Date	Time	Comment	Init.	Date	Time	Comment	Init.

Date	Time	Comment	Init.	Date	Time	Comment	Init.	Date	Time	Comment	Init.

Date	Time	Comment	Init.	Date	Time	Comment	Init.	Date	Time	Comment	Init.

Signatures	Title	Date



Certificate of Examination Of School Personnel for Tuberculosis

Section CC-12.0

This is to certify that _____, No. _____

NAME first, m.i., last

Employee Number

was examined on _____ for the disease of tuberculosis and was found to (be free of)
(have) active

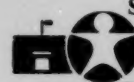
tuberculosis. The following were performed in connection with the examination:

Tuberculin test: DATE: _____ RESULT: _____ Negative reaction
_____ Not done _____ Positive reactionChest X-ray: DATE: _____ REPORT: _____ Normal chest findings
_____ Not done _____ Abnormal chest findings_____
PHYSICIAN'S SIGNATURE

TEXAS MD/DO LICENSE NUMBER: _____

In order to comply with Texas law (VTCS 4477-12, sec. 5), the examination must be completed and the certificate with results must be furnished to the governing board of the public school prior to the commencement of the individual's duties. TB-4, Rev. 8/1/79 (Texas Department of Health).

Student Transfer Record
Healthy Independent School District
Health Services Department
Immunization and Screening Data



Section CC-13.0

Record ALL
Immunizations!

NAME (full) _____ Birth Date _____ Grade _____

Address _____ Telephone _____

Parent or Guardian _____

DPT or Td

Date #1

Date #2

Date #3

Date #4

Date #5

Date #6

Physician

Oral Polio

Date #1

Date #2

Date #3

Date #4

Date #5

Date #6

Physician

Rubeola

Date of Vaccine

Date of Disease

Physician

Rubella

Date of Vaccine

Physician

Mumps

Date of Vaccine

Date of Disease

Physician

Vision

R _____ L _____ Date of Test _____

Hearing

R _____ L _____ Date of Test _____

*Schools are reminded that transfer of immunization records (see Section BB-16.0) and screening results (see Section BB-32.0) ARE
REQUIRED BY LAW.

COMPLIANCE STATEMENT

TITLE VI, CIVIL RIGHTS ACT OF 1964; THE MODIFIED COURT ORDER, CIVIL ACTION 5281, FEDERAL DISTRICT COURT, EASTERN DISTRICT OF TEXAS, TYLER DIVISION

Reviews of local education agencies pertaining to compliance with Title VI Civil Rights Act of 1964 and with specific requirements of the Modified Court Order, Civil Action No. 5281, Federal District Court, Eastern District of Texas, Tyler Division are conducted periodically by staff representatives of the Texas Education Agency. These reviews cover at least the following policies and practices:

- (1) acceptance policies on student transfers from other school districts;
- (2) operation of school bus routes or runs on a non-segregated basis;
- (3) nondiscrimination in extracurricular activities and the use of school facilities;
- (4) nondiscriminatory practices in the hiring, assigning, promoting, paying, demoting, reassigning, or dismissing of faculty and staff members who work with children;
- (5) enrollment and assignment of students without discrimination on the basis of race, color, or national origin;
- (6) nondiscriminatory practices relating to the use of a student's first language; and
- (7) evidence of published procedures for hearing complaints and grievances.

In addition to conducting reviews, the Texas Education Agency staff representatives check complaints of discrimination made by a citizen or citizens residing in a school district where it is alleged discriminatory practices have occurred or are occurring.

Where a violation of Title VI of the Civil Rights Act is found, the findings are reported to the Office for Civil Rights, Department of Health, Education and Welfare.

If there is a direct violation of the Court Order in Civil Action No. 5281 that cannot be cleared through negotiation, the sanctions required by the Court Order are applied.

TITLE VII, CIVIL RIGHTS ACT OF 1964; EXECUTIVE ORDERS 11246 AND 11375; TITLE IX, 1973 EDUCATION AMENDMENTS; REHABILITATION ACT OF 1973 AS AMENDED; 1974 AMENDMENTS TO THE WAGE-HOUR LAW EXPANDING THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967; AND VIETNAM ERA VETERANS READJUSTMENT ASSISTANCE ACT OF 1972 AS AMENDED IN 1974.

It is the policy of the Texas Education Agency to comply fully with the nondiscrimination provisions of all federal and state laws and regulations by assuring that no person shall be excluded from consideration for recruitment, selection, appointment, training, promotion, retention, or any other personnel action, or be denied any benefits or participation in any programs or activities which it operates on the grounds of race, religion, color, national origin, sex, handicap, age, or veteran status (except where age, sex, or handicap constitute a bona fide occupational qualification necessary to proper and efficient administration). The Texas Education Agency makes positive efforts to employ and advance in employment all protected groups.



HEALTH SERVICES
HEALTH EDUCATION
SCHOOL ENVIRONMENT

SCHOOL NURSE HANDBOOK
FOR THE
SCHOOL HEALTH PROGRAM
TEXAS EDUCATION AGENCY



HEALTH SERVICES
HEALTH EDUCATION
SCHOOL ENVIRONMENT

SCHOOL NURSE HANDBOOK FOR THE SCHOOL HEALTH PROGRAM TEXAS EDUCATION AGENCY

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Foreword

The purpose of this handbook, a revision of Texas Education Agency Bulletin 752 (1975), is to assist administrators, and school nurses in planning and implementing the school health program.

Through the educational system, students may be taught the rudiments of self-care and health consumer awareness. Schools are encouraged to provide health education, health counseling, and health screening in order to develop an enlightened student and future adult.

The Texas Education Agency gratefully acknowledges the many contributions made by school nurses and physicians throughout the state. This handbook will provide direction for the school health program.

Raymon L. Bynum
Commissioner of Education

Introduction

Boards of education, in cooperation with state and local health departments and other community agencies, are expected to authorize the necessary procedures for protecting the health of school children.

The school health program is governed by state and federal laws and State Board of Education rules. Legislation provides for the control of communicable disease, vision screening, medication in school, immunizations, and certain curricular offerings. Health and physical education are required in the Texas school curriculum.

Texas Administrative Code (TAC) §85.41 outlines the requirements for the school health program (See Section C-4.1). In addition to these specific rules, the courts have upheld local school board regulations as long as they have not conflicted with state law.

Standards developed by the Texas Department of Health include refinements of immunization requirements, recommendations regarding tuberculosis screening, and vision screening.

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History of the School Health Program

Section A History of the School Health Program

History of the School Health Program

Section A

Introduction

The school health program of today has evolved over 150 years through the interrelationship of three major professions: education, nursing and medicine. This evolution has progressed from an early emphasis on health education and teaching self-care through progressive stages of prevention and detection of diseases, sanitation, intervention of illness and handicapping conditions and health promotion. Now it has returned to teaching students to make responsible decisions regarding self-care.

European School Health Services

The earliest recorded school health service activities began in 1833 with a French law requiring communities to keep school houses clean. A few years later female supervisors of kindergarten schools were instructed to watch over the health of "little children." A Paris statute of 1842-43 required that every school be visited by a physician to "inspect the localities" and observe the general health of the children.[1]

Although France established the first precedents, it was almost 40 years before school health programs were developed in other European cities. In 1874, Brussels established a program by appointing physicians to visit schools three times each month. Similar programs were founded in Antwerp in 1882, Moscow in 1888, Leipzig and London in 1891 and in Weisbaden in 1896.[2] Weisbaden provided the most comprehensive and successful program of health examinations, which was generally adopted throughout Germany and widely copied by other nations.

Efforts toward health protection spread quickly to other countries. An 1899 law passed in Rumania decreed that all school children be examined yearly. Later, the national "Medical Inspection Act" of 1908 enacted by Parliament represented the forerunner of the present school health services in Great Britain.[3]

Shortly after the turn of the century, Argentina established a comprehensive health program which provided for "vaccinations of school children, the inspection of school sanitation conditions, the visiting of sick children in their homes, the identification of communicable diseases, and the provision of medical advice to teachers and pupils." [4]

School health service activities in the United States can be traced to the latter part of the 19th century. However, William A. Alcott, a distinguished educator, physician, and school health pioneer, wrote in 1840:

Until the teachers of the schools can be trained to a thorough and practical knowledge of the science of human life and health there will be a thousand things of frequent, if not daily, recurrence in every school which will require medical attention.[5]

It was 10 years later that the idea of teaching students the philosophy of self-care was first documented. In 1850, Lemuel Shattuck proposed that teachers appoint a "sanitary committee of scholars" at the beginning of school. On the first day of each month the committee should appraise the class. Shattuck stated:

Such a measure is simple, would take but a few minutes each day, and cannot operate otherwise than usefully upon the children, in forming habits of exact observation, and in making a personal application of the laws of health and life to themselves. This is education of an eminently practical character, and of the highest importance.[6]

New York in 1860 passed legislation to "encourage and provide for the general vaccination of all children and persons attending schools in the state." This law established long before compulsory education, recognized the schools as the most organized structure for access to the school-age population. However, the legislation was ineffectual because it did not specify the responsibility for administering vaccinations nor the source of funding. Nevertheless, New York was instrumental in formulating many early school health laws.[7] Later, the Elmira, N.Y., Board of Education (1872) employed a "sanitary superintendent" to cope with an alarming prevalence of smallpox. His responsibilities included: frequent examinations of school children, exclusion of the unvaccinated, and supervision of sanitary conditions.[8]

"The first public school medical officer in the United States was appointed by the City of New York in 1892." [9] By 1894, some 50 "medical visitors" who visited schools each day and examined "all children thought by their teachers to be ailing" were appointed in Boston. Similar programs, "to inspect pupils suspected of having contagious diseases," were begun in Chicago in 1895, New York in 1897, and Philadelphia in 1898.[10]

Broadening Scope of Health Services

By the close of the century, the Connecticut legislature began broadening the scope of school health services when it made the examination of all school children for visual defects compulsory. New York in 1902 required routine inspection of all pupils to detect contagious eye and skin diseases. By 1904 Vermont had passed legislation requiring "annual examination of the eyes, ears, and throats of school children." [11]

Further expansion of the concept and practice of the school health program included beginning of dental health work. In 1898 the Cleveland Dental Society requested that dental inspections be introduced into schools. Yet, it was not until 1910 that all city school children received dental examinations and four centrally located clinics for treatment were established. [12]

Establishment of School Nursing Services

Medical inspections were extended to include "nuisance diseases," such as pediculosis, scabies, and ringworm. Students were excluded from school with little follow-up and many failed to return to school, "remaining truant and contributing to excessively high absenteeism in public schools." [13] To alleviate this problem in New York, a Henry Street visiting nurse was assigned to conduct demonstrations in a few schools. "The nurse counseled parents and encouraged them to secure needed treatment or to follow proper care procedures. The experiment was so successful that the first municipally supported school nursing service in the United States evolved in New York in 1902." [14]

Rapid growth of school nursing services followed. By 1911 a total of 102 American cities employed 415 school nurses. [15] In most instances, the nurses were paid through visiting nurse associations, settlement houses, or similar organizations.

First Special Education Program

The next major change in the school health program was a forerunner of today's special education program health services. "Open-air schools, intended generally for the more efficient care and instruction of physically below-par children" were conceived in Germany in 1904. By 1908 open-air schools had been established in Providence, Boston, New York, and Chicago. "Open-air classes focused attention on the need for controlling tuberculosis and undernourishment in school-age children." [16]

Change in Educational Philosophy

During the first half of the 20th century, educational philosophy shifted from a solely subject matter approach to include attention to child growth and development. Matters such as growth, hearing, vision, nutrition, and general health status began to receive a new emphasis. School administrators became increasingly concerned with services which safeguard good health and have accepted these efforts as essential to effective education. [17]

Expansion of Public Health Activities

Spurred by these changes in the educational philosophy, the expansion of public health activities was begun. "Public health programs related to protecting and promoting child health received emphasis and were directed toward infants, preschool children, and children of school age." [18] The growth of the pediatric field of medicine made great advances in child growth and development, nutrition, and treatment of handicapping conditions.

Impact of World Wars

The impact of a national crisis or emergency produced by World War I and World War II had particular influence on the school health program. Wood and Rowell reported the dynamics of the First World War on school health services:

Because of the war as such and because of the economic readjustments which followed it, the period from 1914 to 1926 may be considered one of a typical progress and of undertermined significance in school health work, except that the poor condition (mental and physical) of recruits served as an impetus of increasing interest in more comprehensive public health programs.[19]

Much publicity was given to the large number of draftee rejections for disqualifying defects during both World Wars. While evaluations were inconsistent, the information caused many schools to reassess their health service efforts. Patty indicates that "almost all of the states enacted laws concerning health and physical education between 1918 and 1921." [20]

Groups Instrumental in Providing Leadership

The cooperative effort of persons from various disciplines has provided a focused direction for the school health program. Professional organizations, voluntary associations, private groups, federal agencies, and colleges and universities have shared guidance and leadership in the development of school health policies and procedures.[21] Major contributors include: Joint Committee on Health Problems in Education of the National Education Association and American Medical Association; American Association for Health, Physical Education and Recreation; American Public Health Association; American School Health Association; American Nurses Association; American Academy of Pediatrics; and the U.S. Department of Health and Human Services.

School Health Today

A more recent look at the school health program both nationwide and in Texas in the later part of the 20th century finds emphasis placed on four major areas: prevention, intervention, promotion, and health teaching. Brophy, consultant for the California Department of Education, states that prevention serves to validate the very nature of school health services. Since the inception of the school health program the emphasis on wellness, prevention of illness and transmission of disease, and early detection of possible defects including follow-up procedures have been given top priority. [22]

With the passage of the Education for All Handicapped Children Act of 1975 (PL 94-142) schools have found it necessary to provide an educational setting for children with many handicapping conditions. Intervention techniques used by school nurses have allowed many students with specialized physical health care needs to be placed in non-clinical settings. Also, school nurses are involved in crisis intervention on a daily basis with students presenting problems related to alcohol and drugs, venereal disease, pregnancy, abuse and neglect, family discord, and many other concerns related to health and personal living.[23]

School nurses often serve as catalysts for promoting health through formal and informal health education. The school health programs require nurses to serve as resource persons, to identify other resources, and to assist in and developing programs in preventive health education.

Conclusion

Many factors have influenced the 150-year development of the school health program. Twenty years ago Wilson, a physician and historian, noted the 20 factors which continue to serve as points of direction today. They include:

1. Successful school health practices in foreign countries, particularly European nations
2. Changes in the philosophy of education
3. Alterations in social viewpoints regarding child health and welfare
4. Expansion of public health programs

5. Medical and scientific progress
6. Impact of health programs stemming from war conditions and other periods of national crisis
7. Development of the behavioral sciences with greater understanding of growth and development characteristics
8. Leadership and inspiration by pioneering individuals interested in the well-being of all school children
9. Contributions by professional health associations, governmental health agencies, voluntary health organizations, and institutions of higher learning
10. Development of organized civic groups whose concern about health stemmed from the interest of school patrons
11. Financial support, particularly in the fields of research, demonstration, and experimentation, by philanthropic organizations interested in child welfare.

These and other factors have shared in the organization, integration, and improvement of programs of school health services. All have contributed directly or indirectly in the development of the philosophy which guides operational practices today.[24]

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Section B

Administration

Section B	Administration
1.0	Components of a School Health Program
1.1	Health Services
1.2	Health Education
1.3	School Environment
1.31	Safety Standards for School Environment—Texas Education Agency
1.32	Recommended First Aid Facilities—Texas Department of Health Resources

Section B Administration

The purpose of this publication is to suggest methods of organizing and conducting an adequate school health program. Initiating and developing the program is the responsibility of the superintendent who, with the support of the board of trustees, relies on the cooperation of the staff, students, parents, and other concerned citizens. Community participation is desirable at all stages of planning, organizing, and implementing the program.

School district administrators will of necessity delegate some of the responsibility to others, particularly to school nurses. In all instances, however, the final approval of the health program including services, personnel, facilities, and budgets, lies with superintendents and trustees.

Components of a School Health Program

Section B-1.0

Three widely accepted components of a school health program are:

- Health Services
- Health Education
- School Environment

The *School Nurse Handbook for the School Health Program* is directed primarily to the administration of the program as it relates to these aspects in accordance with the Texas Administrative Code (TAC) §85.41 (see Section BB-13.0).

Health Services

Section B-1.1

Health services must be comprehensive in design to meet the educational objectives and health needs of its population. Health services should serve all students in affording them the opportunity to reach maximum mental, physical, and emotional potential. Emphasis should be placed on the relationship of a student's health to successful living and learning.

The health services portion of the school health program utilizes personnel from nursing, medical, dental, other professional disciplines, and ancillary health paraprofessionals. The recommended student services provided through a school health services program are discussed in Section F.

Health Education

Section B-1.2

The promotion of health and health education should be the basis for a school health program's immediate, intermediate, and long-term goals. School nurses should make use of every opportunity while talking with students, administrators, parents, and/or community leaders to teach on-going methods of acquiring better health.

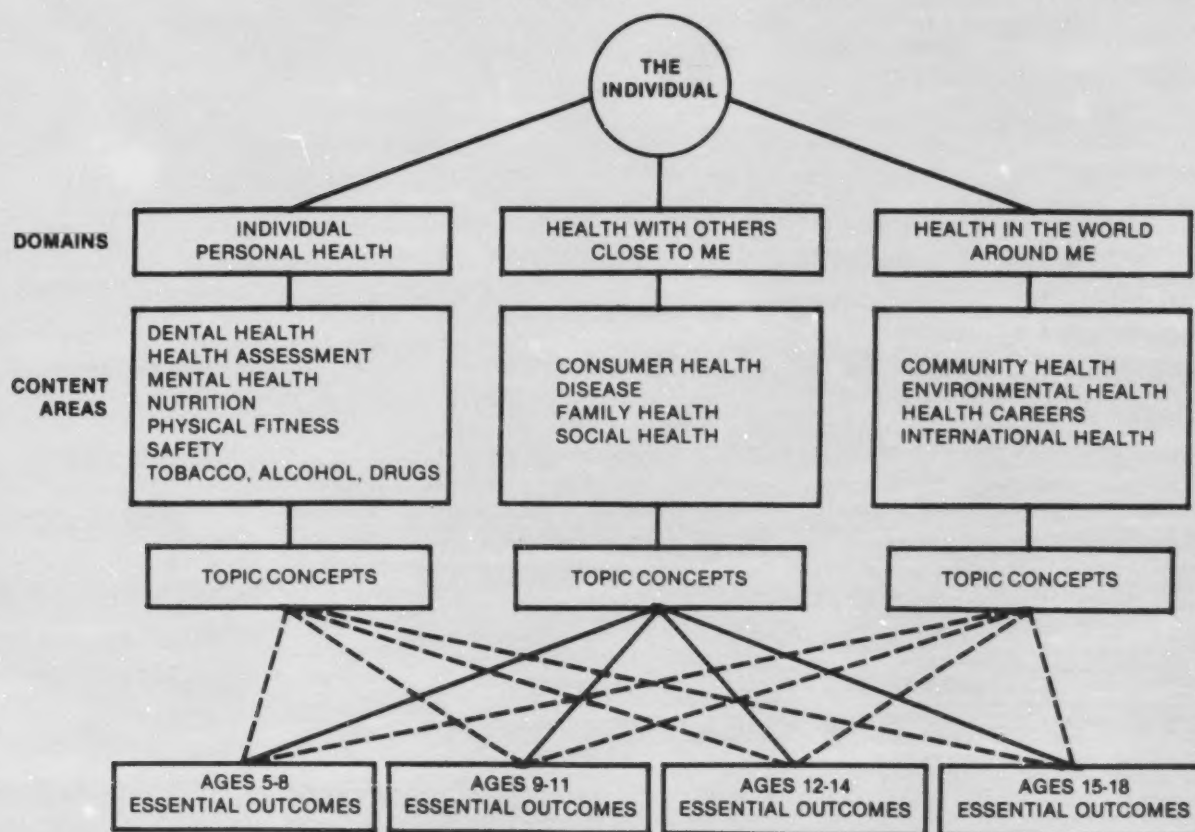
The primary role of the school health program is not one of formal health education. School nurses are not expected to have responsibility for regular health classes. Yet, the school nurse and other professionals—through informal student contact, as guest speakers on health issues, and as health advocate resource persons—have vital input to health education.

Nurse Promotes Health Education By

- Utilizing all screening programs and first aid procedures as learning experiences for the student.
- Assisting the classroom teacher by presenting health concepts in science, biology, home and family living, child development, physical education, and health classes.
- Supplementing the regular classroom curriculum, i.e., dental health, nutrition, drug abuse, smoking, first aid, personal hygiene, and cardiopulmonary resuscitation.

- Observing special health recognition weeks or months as unique educational opportunities, i.e., Health Awareness Week, Dental Health Week, Save Your Vision Week, Correct Posture Month, Nutrition Month, Better Hearing and Speech Month.
- Serving as a resource person for teachers in obtaining special materials such as films and supplies available from community agencies as well as from education service centers.
- Maintaining attractive, relevant bulletin boards of current health interest.
- Serving on special programs for school-community groups such as Parent-Teacher Associations, pre-school, booster clubs, youth groups, and parent involvement groups.
- Serving as instructor for mini-courses such as mother's aide, baby care, home nursing, first aid, nutrition, and grooming.
- Conducting inservice training sessions for school personnel in matters pertaining to health, such as sickle cell anemia, hyperactivity, resuscitation, and first aid.
- Planning and teaching health-related subjects. The following page outlines a *recommended* health curriculum, including domains and content areas related to student age groupings. (*Framework for Health Education, K Through 12*, TEA CU1 832 21, 1981, \$2.00.)

FEATURES OF THE FRAMEWORK FOR HEALTH EDUCATION ORGANIZATIONAL FORMAT



School Environment**Section B-1.3**

A healthful school environment is one in which students can develop a high level of physical and emotional well being. The development of such an environment requires the cooperation of appropriate persons.

Responsibility of School Board

The local board of education and administrators have a direct and continuing responsibility to provide a safe and healthful school environment for students and staff, including the social and emotional factors related to healthful school living.

The physical environment includes adequate ventilation, temperature control, lighting, seating, maintenance, and safety of buildings and grounds. The environment must be barrier-free or accessible for students with all types of handicapping conditions. This does not mean every facility must be accessible and barrier-free, but rather that the program is accessible in some way to a student with a handicap.

The mental/emotional climate of the school is less tangible. It includes the interaction of students with one another, students with teachers, teacher with teachers, and teachers with administrators. All service staff personnel share in the promotion of positive mental/emotional health within the school.

Each person needs acceptance, recognition, and security to achieve. A healthy emotional climate, providing acceptance, recognition, and security must be nurtured and maintained. Schools are educational facilities where skills for living are learned by example as well as precept. Skills include development of positive health attitudes and practices of students, assistance in making decisions for health or health care, and reinforcement of good health practices learned at home.

Planning and organizing the school day are important aspects of the emotional climate. Scheduling should include time for students to take care of basic physical needs. Change of activity with physical exercise helps to improve learning. Proper emphasis on healthful living habits in the school can influence the student in later life.

To a large degree the healthful school environment is influenced by the attitudes and values of the total school population—students and staff. It is a joint responsibility and can only be achieved through cooperative planning and efforts.

Role of the Nurse

The school nurse is an administrative team member, serving as an advisory and resource person. The nurse must observe environmental factors and, if necessary, convey any concerns regarding sanitation or safety hazards to the principal and the health program administrator. The nurse should emphasize the need for continuing safety awareness in the school.

Nurse May Assist Through

- Periodic inspection of school buildings and grounds for safety and sanitary conditions.
- Periodic inspection of cafeterias.
- Suggestions to the school safety council.
- Work with the principal for correction of undesirable conditions found on the school premises.
- Promotion of satisfactory heating and lighting.

**Safety Standards for School Environment
Texas Education Agency****Section B-1.31**

- Buildings must be fire and wind resistant, preferably not more than two stories in height unless it is necessary to build on a small site.
- Corridors, stairways, and all other features of building construction should meet local, state, and national building standards.
- There should be at least two exits in all buildings.
- Outside doors should be equipped with self-closing devices and panic bolts which should be inspected, oiled, and tested regularly.
- Exit doors from classrooms should open outward and be provided with door checks which hold the door against the wall when open.
- Auditoriums, gymnasiums, and other rooms used by large groups should be located on the ground floor for ready exit.
- Sanitary facilities, toilet rooms, washrooms, and drinking fountains should be in sufficient numbers and located to prevent congestion and facilitate adequate cleaning.
- Lighting in rooms, hallways, stairways, basements, locker rooms, toilet rooms, and store rooms should be adequate with lights at the head and foot of stairs and where needed to prevent accidents and protect vision.
- School furniture and equipment must be safe, regularly inspected, and kept in repair. Machines in shops and laboratories should be equipped with approved safety devices.
- Safety hazards such as slippery floors, splintered doors and handrails, and projections or obstructions in rooms, hallways, and stairways should be eliminated.
- The school building and playground should be in clear view from any direction when approached on the street. Warning signs should be erected and be seen easily by motorists.
- Police officers, caution signs, school safety patrols, and stop lights should be available to protect children at hazardous crossings.
- The school site should be located away from railroads, industries, dangerous streams, and anything which disturbs school by noises or odors.
- School grounds should be level, but with sufficient drainage. Grounds should be free from rocks, holes, ditches, and other obstructions.
- Play areas, if adjacent to streets, should be fenced.
- Safe parking areas, including loading and unloading zones for school buses, should be provided.
- Service driveways should be fenced or marked and should not cross play areas. Driveways should extend from street to school only, and not pass the school to another thoroughfare.
- Flagpoles, monuments, garbage incinerators, and other obstructions should be located away from play areas.
- Playground activities and equipment should be properly supervised. All teachers should receive instructions on proper use of equipment and pass these instructions on to the students.
- Repairs should be made immediately. Inspection of all playground equipment should be made on a regular basis.

**Recommended First Aid Facilities
Texas Department of Health Resources**

Section B-1.32

1. The first aid room should be in a centralized location.
2. A room should be available for isolation and/or rest for ill or injured students.
3. A bed or cot should be available in the first aid room.
4. A lavatory with hot and cold water should be available in the first aid room.
5. The first aid room should be equipped with an adequate amount of the proper first aid supplies based on needs and usages for the particular facility. The equipment should comply with the list in the Red Cross Manual "Standard First Aid and Personal Safety," and a copy of this manual or its equivalent should be available.
6. First aid supplies should be stored in a locked cabinet, or the first aid room should be locked when unattended. Keys should be readily available with supervised use of supplies.
7. A registered nurse or person trained in first aid should be available in the facility at all times. Training should be provided by a Red Cross instructor or equivalent, licensed physician, or registered nurse.
8. A plan to provide emergency medical treatment to seriously ill or injured persons should be established, and emergency telephone numbers should be posted and readily available.
9. Emergency plans should also be established for weather and fire emergencies.
10. The first aid room and equipment should be kept clean at all times.
11. First aid supplies should be replaced as used so that adequate supplies will be available at all times.
12. Signed permission from parent, guardian, or physician should be obtained before any drugs are administered to a minor, as required by Chapter 35, Title 2 of the Texas Family Code. Records should also be maintained on any medication administered.

Texas Department of Health, "Recommended Environmental Health Practices for Schools" (Austin, Texas: The Department, 1977).

Section C

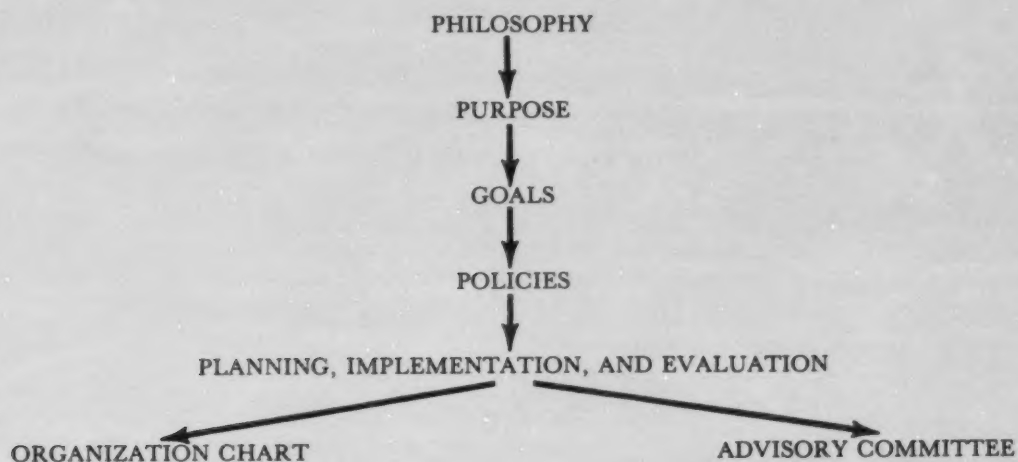
Framework—Guidelines

Section C	Framework—Guidelines
	1.0 Developing a Philosophy
	1.1 Sample: School Health Program Philosophy
	2.0 Developing a Purpose
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	3.0 Developing Goals
	3.1 Sample: Goals for a School Health Program
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Section C

Framework—Guidelines

The framework of a school health program is composed of several components. Each element of the framework should build and gain impetus from the other; yet, be an understandable entity. The following components are suggested for a well-coordinated health program.



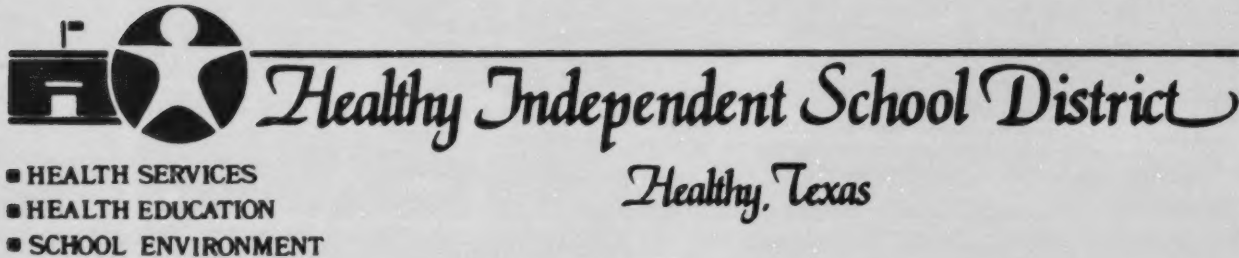
Developing a Philosophy

Section C-1.0

A program's philosophy is the cornerstone or foundation of its existence. The philosophy provides a point of view, a statement of values, an aspiration for ideal possibilities, and the significance or relationship of concepts pertaining to a school health program. The philosophy answers the question of *why* a health program exists and also queries its *worth*. It lends direction for a program's purpose, goals, and objectives.

A philosophy should be developed jointly by school nurses and administrators and contain emerging concepts which are held important to the local district, personnel, and the health program. Constructs which may be addressed in a school health program philosophy are: the student, health, nursing, health services, and the school.

Section C-1.1



School Health Program Philosophy

The faculty members of the school health program support the philosophy of Healthy Independent School District. In accordance with this philosophy we believe in the holistic student, affirmed as having inalienable rights, intrinsic value, dignity, and responsibility. The student is accepted without judgment in terms of biological, socio-economic, political, cultural, religious, and emotional complexities.

Health is recognized not exclusively as the absence of illness or disease, but as the most desirable level of physiological, psychological, and emotional well-being. We believe that all students have the right to learn how health may better be achieved.

School nursing is acknowledged as being a helping profession. School nurses are student advocates and serve as liaisons between the student, school, community, and home.

The school health program is a vehicle in the advancement of student, staff, and community health and welfare. The program provides assistance in the discovery of barriers which may be hinderances to student learning.

One of the major principles of education has been the achievement and maintenance of good health. The school is an avenue through which meaningful preventive health measures may be initiated. The school setting has a unique advantage in: the promotion of health education; the development of positive healthful attitudes; the maintenance of an environment conducive to optimal health, growth, and learning; and meeting the needs of school students and school personnel.

Developing a Purpose

Section C-2.0

The school health program purpose should be agreed upon and stated by district administrators and nursing administrators. A program purpose is a continuum of the philosophy; it provides direction and information regarding the aim and intent of the health program.

The following sample purpose states the basis for a program and refers to legislative documentation found in TAC §85.41, provided in Section C-4.1, of this handbook.

Section C-2.1



Healthy Independent School District

Healthy Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Health Program Purpose

It is the intent of the school health program to provide health counseling, appraisal, screening, referral, and follow-up through program planning, development, and evaluation.

The primary purpose of Healthy Independent School District's school health program is the optimal maintenance, promotion, protection, and improvement of student, staff, and community health. The school health program personnel work collaboratively with students, parents, educators, staff members, and other community resources to assist the student develop competence to confidently cope with the complexities of life. The program is designed to assure a safe, healthy environment that is conducive to learning, and to provide professional care for those who become ill or injured while at school.

The school health program is no substitute for the health care which parents should provide for children. Rather than relieving parents' responsibilities, this program is established to encourage individuals to utilize the services of a private physician, dentist, optometrist, and/or community health agency.

Developing Goals

Section C-3.0

The goals for a school health program should correspond to the educational goals of the school district. Goal formation follows the establishment of a health program's philosophy and purpose. A program's goals should state achievable expectations derived from problems which have solutions. Goals are statements of *what* a program plans to do and progress to development of district health policies.

Steps in Goal Development

1. Assessment of needs.
2. List goals in order of priority.
3. Evaluate effectiveness of goals achievement.
4. Re-assess needs or new goal formation.

Three areas to be addressed in goals are: Health Services, Health Education, and the School Environment.

Health Services

1. Maximize the quantity of in-class time by reducing the incidence of health-related absenteeism.
 - Decrease the incidence of preventable communicable disease.
 - Ensure adequate immunization in all students.
 - Exclude students with symptoms of communicable disease.
 - Adjust school environment to accommodate student health problems which cause absenteeism.
2. Eliminate or minimize health problems which impair learning by maintaining a health appraisal schedule for students for detection and referral of health problems.
 - Achieve a minimum of 95% referral completion rate for vision and hearing defects.
 - Administer medication according to law and school board policy.

Health Education

1. School nurse to serve as a resource person to elementary teachers and/or secondary health educators.
2. School nurse to conduct selected classroom sessions where appropriate.

School Environment

1. Survey school building and grounds for safety hazards.
2. Comply with government requirements/recommendations regarding food service, housekeeping, and maintenance.



Healthy Independent School District

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

Healthy Texas

Goals for a School Health Program

1. To augment health instruction which guides students toward reaching full capacity as individuals who make responsible decisions about personal, family, and community health.
2. To advocate and help provide an environment conducive to the promotion and maintenance of health.
3. To detect and to provide nursing care for any physical condition which impedes learning or threatens optimum health. (Nursing care is defined as assessment, intervention, counseling, and/or referral of any physical conditions.)
4. To provide liaison among the school, home, community agencies, physicians, and other health personnel.
5. To provide a physical, mental, and emotional health advocate for children within the school.
6. To achieve acceptable levels of compliance with federal, state, and local health regulations.
7. To maintain and utilize current individual and collective health data.
8. To provide learning and growth experiences for staff members.
9. To evaluate the program's effectiveness.

Developing Policies

Section C-4.0

Texas Administrative Code §85.41 (see Sections C-4.1 and 4.2) lists 13 items in which districts must have written policies for school health service programs. These policies, along with others pertinent to individual districts, are invaluable for the planning and development of a program. Laws governing the practice of school health services, health education, and a healthful school environment are compiled in Section BB.

Professional organizations in the community particularly interested in health promotion, such as nursing, medical, dental, or optometry, may be of assistance in the initiation of policies.

TAC §85.41 and a clarification outline are provided in the following sections to assist districts in the compilation of school health program policies.

Texas Administrative Code (TAC) §85.41

Section C-4.1

Health Services Program

a) School health services shall be considered as part of the educational program of the school children of Texas. These services shall be provided to all children through local education agencies in accordance with the provisions of Subchapter D of Chapter 97 of this title (relating to Principles, Standards, and Procedures for the Accreditation of School Districts), and standards established by the Texas State Department of Health and in accordance with applicable laws. The local education agency shall ensure appropriate coordination of school health services, other student services, and related instructional programs.

b) School health services shall be addressed by policies of the local board of trustees. Local policies shall address the following functions:

1. planning, development, and evaluation;
2. health counseling;
3. screening;
 - (a) vision (Texas Civil Statutes, Article 4419f, and
 - (b) hearing;
4. prevention and control of communicable diseases;
 - (a) immunization (Texas Education Code §2.09); and
 - (b) exclusion and reporting of students or employees who have communicable diseases (Texas Civil Statutes, Article 4477);
5. provision for emergency cases;
6. consultation and coordination with other student services and related instructional programs to focus on the health-related needs of students and their families (including but not limited to special education and health education);
7. liaison with community health resources;
8. referral and follow-up to ensure that parents have been notified of identified problems and know how they can obtain needed services for their children;
9. health appraisals of students;
10. maintenance of pupil health records;
11. reporting child abuse (Texas Civil Statutes, Article 3401 et seq.);
12. administration of medication by school personnel (Texas Education Code §21.914); and
13. eye-injury reporting and eye-protective devices (Texas Education Code §21.909).

Issued in Austin, Texas on September 18, 1981.

Doc. No. 816665

Raymon L. Bynum, Commissioner of Education

Effective Date: October 9, 1981

Clarification Outline Texas Administrative Code §85.41

Section C-4.2

I. Planning, Development, and Evaluation:

In order to provide comprehensive school health and health maintenance services that comply with the accreditation standards, a school district must carefully plan, efficiently develop, and thoroughly evaluate the program. The school health program should be based upon an annual needs assessment. The program plan should address short and long-term goals and objectives.

Once the annual projection of student needs is made, the district must identify the resources for provision of the health program. A realistic school nurse/student ratio should be established. Consideration should be given to student needs and to health services planned. The goals and objectives of a school health program should be reviewed frequently for relevance and applicability to the individual school district.

The implementation of a school health program focuses on who will receive the services, how services will be provided, and who will provide the services. Districts must establish priorities for student services and organize time frames for screening schedules, referrals, and follow-up procedures. Recognition must be made for time allotment for student emergencies and illness, health counseling, health teaching, and health appraisals.

The evaluation provides a summation of the health program efforts. It points out areas where change is needed. An evaluation reveals strong and weak points. Evaluation results are helpful in planning continuing education or inservice programs.

Every phase of the school health program should be planned. The use of the principles and standards for accreditation provides guidance in establishing a priorities plan. The plan should:

- A. Express long-range and annual objectives for the school health program.
- B. Outline the major activities which are designed to achieve these objectives, and
- C. Define the ways and means by which progress will be determined.

The accreditation planning process further states:

If a plan is to serve as a guide for action, it must be clear to those responsible for its implementation. The plan must describe to its users: (1) the outcomes being sought, (2) the major activities to be carried out, (3) the roles of various staff members, (4) the target date or dates for completion, and (5) the ways in which progress will be determined. (see Section C-5.0)

II. Health Counseling:

Health counseling, a helping relationship designed to assist students and parents in meeting health care needs, consists of:

- A. Health maintenance, providing information and support in coping with illness and disability, and consumer options for making health care choice.
- B. Crisis intervention for situations involving drug abuse, child abuse, suicide threats or attempts, or other indications of acute stress.

Health counseling shall be provided to students identified through the health appraisal process, a referral by the principal, teacher, parent, self, or other school departments.

Health counseling implies a one-to-one communication between a health professional and a student, parent, or staff member. It generally centers around a child with a specific health problem (such as asthma, diabetes, or seizure activity), and includes a review of ways of adjusting student schedules. The distinction is made between health counseling and health education, in which groups of children receive general health information to assist in decision making (see Sections E-7.0 and 8.0; F-1.0)

III. Screening:

A. Vision

The Texas Children's Vision Screening Act requires all children enrolling in school in Texas for the first time to submit within ninety (90) days after admission a certificate which states that the child has either (1) been examined by a physician licensed to practice in the United States or an optometrist licensed to practice in the United States, or (2) undergone a vision screening test which has been approved by the Texas Department of Health and which discloses the results of the examination or test. There is a provision for admittance upon submission of an affidavit signed by the parent that the child will undergo the required screening test or examination "as rapidly as feasible." Students who attend schools with on-going vision screening programs will not be required to present a certificate from a source outside the school system since there is a provision for the certificate to be signed by authorized school personnel, who have undergone special training. This became effective September 1, 1980. (see Section F-6.0)

B. Hearing

Hearing screening, while not mandated by law, is required by State Board of Education policy. It is necessary to determine the hearing status of students which may directly affect the learning process. Most school districts have been engaged in hearing screenings for several years. Districts are encouraged to arrange hearing screenings in concert with vision screenings, perhaps on alternating years. The Texas Department of Health provides instruction and registration of audiometric users (hearing screeners) and calibration checks of audiometers. (see Section F-7.0)

C. Other

The school nurse health appraisal traditionally includes assessment of dental status, nutritional and musculoskeletal status through measurement of height and weight, blood pressure, inspection of the skin and scalp, and a search for other visually discernable abnormalities such as scoliosis. (see Sections F-3.0, 4.0, 5.0, 8.0, and 9.0)

IV. Prevention and Control of Communicable Diseases

The school shall be responsible for maintaining immunization protection levels to reduce incidence of preventable diseases not amenable to immunization. Pediculosis and scalp ringworm screenings should be conducted for early identification and control. (see Section E-4.0)

A. Immunization (see Section BB-15.0 for detailed explanation)

Recent changes:

1. Mumps vaccine: At least one dose of mumps vaccine, or a history of mumps illness, validated in writing by a physician licensed to practice medicine in the United States, is required. Effective each September 1, this requirement must be met by students as designated. Age of the student is determined by age on September 1. See following table.

Mumps Immunization Requirements

Effective Dates	Age as of September 1
September 1, 1982	Thru 10 years
September 1, 1983	Thru 11 years
September 1, 1984	Thru 12 years
September 1, 1985	Thru 13 years
September 1, 1986	Thru 14 years
September 1, 1987	Thru 15 years
September 1, 1988	Thru 16 years
September 1, 1989	Thru 17 years
September 1, 1990	Thru 18 years and older

2. The requirements of Measles (Rubeola) immunization for all students was effective during the 1981-82 school year.

V. Provision for Emergency Cases

Well organized plans of action for the care of emergencies should be written by the district. An emergency ambulance telephone number should be known by building personnel and posted in conspicuous places. Schools should have readily available emergency information, provided by a parent/guardian, on each student. It is highly desirable that as many individuals as possible beyond health professionals be trained in first aid and cardiopulmonary resuscitation. (see Section E-3.0)

- VI. The school health program will utilize consultation and coordination of other student services and related instructional programs which focus on the health-related needs of students and their families; including, but not limited to, special education, health education, vocational or industrial arts education. (see Sections B, F, H, and AA)

VII. Liaison With Community Health Resources

Schools do not attempt to provide comprehensive nor primary health care, which is the responsibility of the parent. However, it is reasonable and cost effective to identify health barriers to learning and to assist with their correction or amelioration. In order to achieve this, community resources must be identified and good working relations established. This may best be done through a health advisory council composed of community health professionals, other professional groups, and parents. In addition to creating valuable links with health resources, this group may assist with formulating policies and procedures at the local level. (see Sections C-7.0 and AA)

VIII. Referral and Follow-Up

Following health screening, identified problems which may interfere with student learning will require attention to determine whether correction is possible. Primary responsibility lies with the parent, the family physician, and/or community health sources. School health professionals may assist the family in locating community resources for referrals. Follow-up implies a school nurse checking to ensure that the child did in fact see a physician or health care provider. Little is accomplished by appraisals and referrals unless a plan of work includes careful follow-up and recording of the findings, many of which may require an adjustment in the school environment.

IX. Health Appraisals of Students

Health appraisal of students by the school nurse may be: a formal individual physical exam including all body systems; mass screening processes; determining need for emergency or illness care; health counseling for health maintenance or crisis intervention; the administration of medication or providing special health care services; or any other contact with a student. Student health appraisal is an integral part and an on-going process of the entire school health program.

X. Maintenance of Student Health Records

Records in school health programs serve three primary purposes: administrative, medical, and educational. Administrative health records show which children have received mandated immunization, screenings, and examinations. Accident reports are also considered administrative records. Medical health records form the data base for medical care of individual children when the school assumes responsibility for health supervision of students. Clinical records include both positive and negative findings, growth charts, immunization procedures, and treatment plans. Educational health records indicate health-based recommendations for special management or observation of students while they are in the school. This information is needed for every school child regardless of responsibility of health supervision. (see Section CC)

XI. Reporting Child Abuse

"Any person having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect shall report in accordance with TEC §34.02. An individual reporting in good faith has protection from legal liability. Failure to report is punishable by fine and/or imprisonment." (see Sections E-7.0 and 7.1)

XII. Administration of Medication by School Personnel

A summary of the law includes these salient points. The board of trustees of each school district shall adopt policies concerning the administering of medication to students by employees of the district. These employees shall have immunity from civil liability from damages or injuries resulting from the administering of medication to a student if (1) the school district has received a written request to administer the medication from the parent, and (2) when administering prescription medication, medication appears to be in the original container and to be properly labeled. This should include the student's name and dosage directions. "Nothing herein should be construed to grant immunity from civil liability for injuries resulting from gross negligence." (Legal liability would be incurred if a school employee gave one child's medication to another child.) Records of medication administration during school hours should be kept, and indicate the time and the person administering the medication.

It is recommended that only medication *provided* by parents/guardians be dispensed by school personnel. (see Sections E-3.2 and BB-19.0)

XIII. Eye Injury Reporting and Protective Eye Devices

"Industrial quality eye protective devices shall be worn by every teacher and student in Texas participating in any of the following courses: vocational or industrial art shops or laboratories involving experience with (a) hot molten metals; (b) milling, sawing, turning, shaping, cutting, or stamping of any solid materials; (c) heat treatments, tempering, or kiln firing of any metal or other materials; (d) gas or electric arc welding; or (e) caustic or explosive materials; or (f) chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids. The governing boards and administrators of Texas school districts offering any of the listed courses are responsible for furnishing free of charge or providing at cost to teacher and students participating in the courses the required eye-protective devices."

Whenever an accident occurs during the conduct of any of the courses described and an injury to the eye of a teacher or student results, the principal shall make a full written report of the accident and injury to the Texas Education Agency. (see Section E-3.1 and BB-8.0)

Planning, Implementing, and Evaluating The School Health Program

Section C-5.0

One of the areas in which school districts must have a written policy is regarding the plan for providing a health program, including the implementation and evaluation. Planning should be directed toward both short and long term goals. Each person concerned with the school health program should have knowledge of its overall goal and the function of specific personnel.

It may be helpful for a district to make policy statements in very broad terms; goals in clear, concise, measurable statements; and extend these statements into specific action plans in a procedure manual.

Example

- Policy:** Healthy Independent School District will provide for emergency care of students and staff while at school or during school-sponsored activities until a parent or guardian may assume a student's care.
- Goal:** The goal of Healthy Independent School District is to provide emergency care for students or staff who become ill or injured while at school or during school-sponsored activities until a parent or guardian may assume a student's care.
- Procedure:** Healthy Independent School District will provide:
- Clinic facilities on each campus in accordance with the recommendations for "First Aid Facilities"—Texas Department of Health (provided in Section B-1.32).
 - Current emergency information cards on each student and staff member (see Section CC-4.0 for sample).
 - Emergency telephone numbers posted conspicuously and known to personnel.
 - Adequate amounts of first aid supplies.
 - Written emergency disaster plans and actions (see Section E-2.0).
 - Daily log notations of students seen in the clinic (see Section CC-1.0).
 - Annual evaluation of emergency care provided students and staff, including re-evaluation or adjustment of policy, goals, and procedures as needed.

A systematic, on-going approach for evaluation of the school health program includes procedures for collecting, analyzing, and interpreting data. Forms which may be helpful are a daily clinic log and a summative report on health services activities (see sample forms in Section CC). Revisions or re-evaluation of goals and procedures may be based on interpretation of data findings.

Four Basic Steps to the Evaluation Process

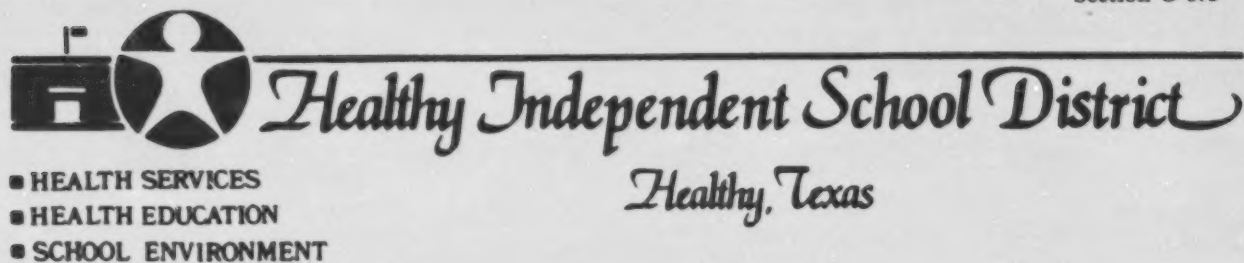
1. Define the program's goals and objectives.
2. Appraise the present program's progress.
3. Gather documentation of services provided.
4. Make recommendations regarding present and future program services (re-evaluation).

Organizational Chart

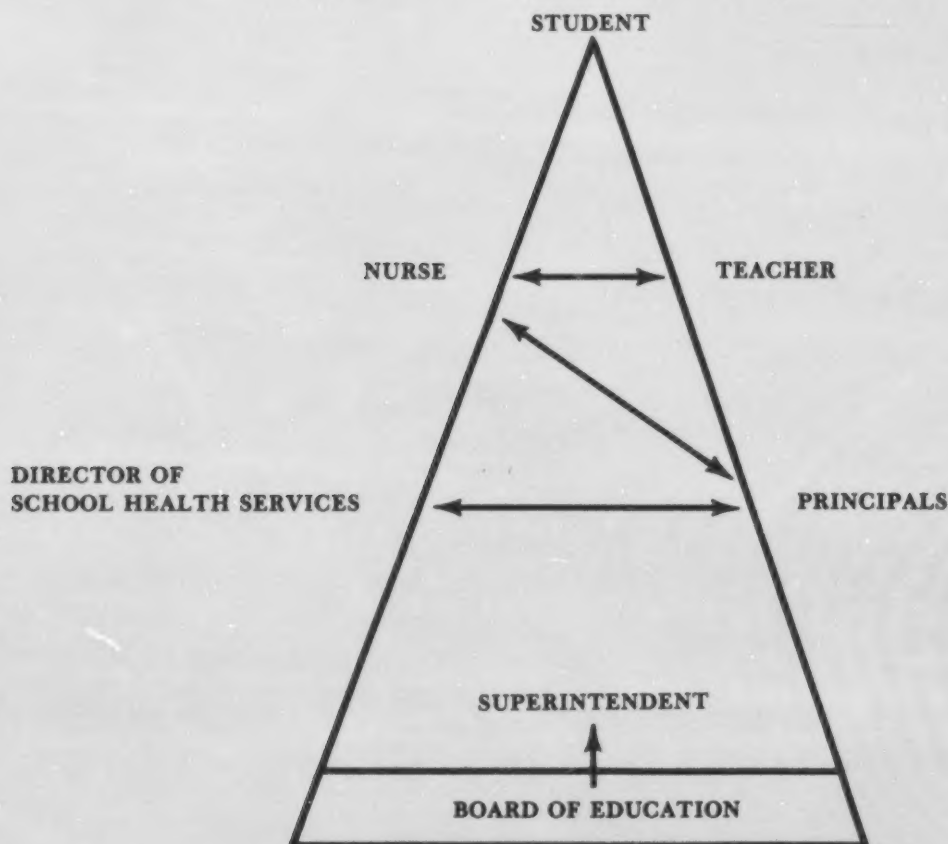
Section C-6.0

An organizational chart of the school district illustrates continuity of responsibility for the school health program. The chart may vary in detail according to the size of the district but should be provided for assistance to the new, as well as the experienced personnel. The following chart provides an example, presenting the student at the apex of a health program.

Section C-6.1



Organizational Chart for a School Health Program



Advisory Committee

Section C-7.0

Purpose

The School Health Program Advisory Committee should have one purpose: to help build and improve a strong district-wide health program.

Designed to provide close liaison between the schools and members of the local health professions, the committee would:

1. Provide school administrators with current information on health procedures and equipment.
2. Provide professional advice in designing and presenting effective instruction to students.
3. Assist in designing and conducting health screening procedures.
4. Promote a strong program of school-community relations in the health field.

Organization

A well-designed plan is essential for developing a productive advisory committee. This plan should include a strong, well-defined purpose for the group, for without it the committee will flounder and eventually collapse. Once the purpose has been defined, the following steps should be taken:

1. Draft a complete proposal, including the committee's purpose, suggested membership, long range goals and short term objectives, meetings schedule, and organization.
2. Present this proposal to the district superintendent.
3. Work cooperatively with the school district administration in drafting or implementing necessary changes in the plan.
4. Assist the superintendent in presenting the proposal to the board of education.
5. Implement the plan under the direction of the superintendent or his representative.

Membership

A well-planned and effective advisory committee should broaden the perspective of the school district staff. For this reason, prospective members should be selected both for knowledge of the health field and broad viewpoint concerning the needs of the public schools.

Professional members of the committee should be drawn from the nursing, medical, dental, and medical technology fields. Additional viewpoints would be brought by interested parents and members of other community groups. However, care should be taken to keep the committee small enough to be workable and effective. Advisory groups usually function best when membership ranges from five to 15 persons.

Operational Practices

The effectiveness of any advisory committee will depend on its sense of purpose, its own elected leadership, and the guidance it receives from the district. While operational practices will vary in detail with individual advisory committees, the following elements are common to most groups:

1. A clear definition of purpose should be prepared and presented both orally and in writing by the district representative assigned to work with the committee.
2. An outline of the district's plans for health services and related activities should be presented by the superintendent or a top level representative.
3. Specific tasks or objectives related to these plans should be presented to the committee, along with a suggested time line or schedule.

4. A program of work, including individual responsibilities of members, should be planned and implemented under the leadership of the committee's elected chairman.
5. Reports of progress based on committee recommendations should be presented by the district liaison staff member on a regular basis. If any recommendation is not implemented, the committee should also be told the reasons and be given suggestions for possible new directions.

Organization

Strong leadership is essential for any committee or group of people to function as a unit. For this reason, the original membership roster must include individuals with both professional knowledge and the ability to work effectively as group leaders. Each committee should include:

1. Elected officers, probably including chairman, vice chairman, and secretary.
2. Stated terms of service for members.
3. Procedures for establishing subcommittees.
4. Provisions for compiling committee minutes, setting schedules.
5. Procedures for replacing members.

Section C-7.1



Healthy Independent School District

Healthy Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Health Program Advisory Committee Statement of Purposes (Charter)

The Board of Education of HEALTHY INDEPENDENT SCHOOL DISTRICT authorizes the establishment of the HEALTHY INDEPENDENT SCHOOL DISTRICT School Health Program Advisory Committee on this

_____ day of _____, _____. The function of the HEALTHY INDEPENDENT SCHOOL DISTRICT School Health Program Advisory Committee is to provide advice and counsel to the nursing and administrative staff of the School Health Program. It is not given authority for policy decisions, and is expected to operate within the guidelines set forth.

The purpose of the School Health Program Advisory Committee is to contribute to the improvement of health services, health education, and a healthy school environment in the HEALTHY INDEPENDENT SCHOOL DISTRICT through such functions as:

- verifying the need for health instruction, screenings, and procedures;
- providing input on staff, equipment, and facilities that is both current and relevant to the school child's needs; and
- promoting community public relations.

_____, Chairman

_____, Superintendent

Section D

School Nursing Services

Section D	School Nursing Services
	1.0 Personnel
	1.1 Nurse Administrators
	1.2 School Nurse Practitioners
	1.3 Staff Nurses
	1.4 Nurse Extenders
	1.41 Licensed Vocational Nurse and/or Nurse Aide
	1.42 Volunteer/Adult and Student Assistant
	2.0 School Nurse Certification—Texas Education Agency
	3.0 School Nurse Evaluation
	3.1 Sample 1: School Nurse Evaluation Form
	3.2 Sample 2: School Nurse Evaluation Form

Personnel

Section D-1.0

Nurses are professionals who may be most helpful in the promotion of good health for the entire school community. Research and practice indicate that a registered nurse to student ratio of 1:1000 or less is needed to provide quality care for students. Districts are encouraged to work toward a staffing level that will assure optimal care in the provision of health services.

It is suggested that the school nurse function in one of the following capacities, based on professional preparation: nurse administrator, nurse practitioner, or staff nurse. In organizations of two or more nurses, a coordinator should be appointed. Nurse-extenders such as vocational nurses, nurse aides, and volunteers may also be of assistance.

The school nurse is a registered professional nurse with or without a baccalaureate degree. Certification by the Texas Education Agency is not currently required but is available under the Texas Education Agency Requirements for School Nurse Certification.

Responsibility for the school health program lies with the district administration. Direct operation is usually delegated to the school nurse. In larger school districts, the nurse may serve as a manager, referring tasks to persons with specific training. In smaller districts, the nurse may provide all the services. For the sake of clarity, "school nurse responsibilities" are defined globally; local districts must decide which duties may be designated.

All school nurses are reminded to include the title of "R.N." with signatures and to wear insignia identifying this title.

Texas Statutes Regulating the Practice of Professional Nursing, as amended, 1981. Board of Nurse Examiners for the State of Texas, Austin, Texas; Article 4522. Use of Title "R.N." Registration Bureaus:

"A nurse who has received his or her license according to the provisions of this law, shall be styled a "Registered Nurse," and may use the title or abbreviation "R.N." When a licensed registered nurse is on duty providing direct care to patients, the nurse shall wear an insignia identifying the nurse as a registered nurse."

Nurse Administrators

Section D-1.1

The nurse administrators are responsible for the organization and delivery of a comprehensive and effective school health program. The American Nurses Association, Commission on Nursing Services, distinguishes three levels and responsibilities of nurse administrators.

Executive Level

Responsibilities of the nurse administrators include:

1. Participating in the administration of the total health care agency.
2. Determining clinical and administrative goals and directions of the nursing department.
3. Devising departmental functions and activities to achieve goals.
4. Acquiring and allocating resources for the determined functions and activities.
5. Evaluating and revising the organizational goals, structures, activities, and resources of the nursing department.
6. Providing leadership in problem solving.
7. Providing leadership in human resources development and personnel management.
8. Providing channels for consumer input into policy development.

Middle Level

Responsibilities of middle administrators may include:

1. Participating in nursing policy formulation and decision making.
2. Problem solving and supervising the delivery of nursing care.
3. Evaluating care provided.
4. Collaborating with other departments.
5. Coordinating staff activities.
6. Staffing and scheduling of personnel.
7. Arranging for equipment and supplies.
8. Recruiting and selecting personnel.
9. Evaluating staff for promotions and transfers, disciplinary action, and separation of service.
10. Providing orientation, training, and continuing education for staff.
11. Undertaking or facilitating research activities.
12. Providing and coordinating clinical learning experiences for students.

First-Line Level

Responsibilities of first-line administrators typically include:

1. Providing for direct nursing care services to clients.
2. Evaluating nursing care given and assuring appropriate documentation, guidance, and supervision of staff members.
3. Selecting nursing personnel for hire.
4. Evaluating staff, including disciplinary action and separation from service.
5. Providing for teaching and staff development.
6. Coordinating nursing care with other health services.
7. Participating in and involving staff in nursing research.
8. Providing clinical facilities and learning experiences for students.

School Nurse Practitioners**Section D-1.2****Criteria**

- Education: registered professional nurse with academic preparation at baccalaureate or higher level
- Certification: School Nurse Practitioner
- Experience: number of years to be established by individual school district

Functions

- Perform physical examination in the following situations:
 - Students needing physical examination for special services.
 - Students needing physical examinations as a prerequisite to participation in athletic programs.
 - Students needing a total assessment to determine possible health barriers to learning.
- School nurse practitioners will be able to:
 - Serve as health advocates for the child.
 - Identify the health status of the child by securing and evaluating a thorough health, developmental, and social history from the parent. Recording of data must be succinct and systematic.
 - Develop individual plans of care and management for health, behavior, and learning problems which may include appropriate referrals and interdisciplinary planning.
 - Interpret student health status with teachers and other school personnel, and provide guidance regarding adjustments and management of educational and health programs for students.
 - Perform developmental evaluations and appropriate screening tests; initiate and participate with other health and educational professionals in assessing normal variations and abnormalities of motor, cognitive, and perceptual aspects of child development.
 - Assist in determining the presence of significant emotional disturbances and psychoeducational problems of childhood and adolescence.
 - Participate in developing and coordinating health care plans involving child, family, school, and community to enhance the quality of health care and to diminish fragmentation and duplication of services.
 - Participate in the implementation of the health education curriculum.
 - Provide health education to individuals and groups; apply methods designed to increase each person's motivation and ability to assume responsibility for own health care.
 - Participate in peer review of school nurse practitioner practice.
 - Document and evaluate individual school nurse practitioner practice on a continuing basis for administrative and policy purposes.
 - Assist in the implementation of federal laws which affect the health, well-being, and educational planning of the school aged child.
 - Establish and maintain a professional liaison with a specified physician for consultation service.

Staff Nurses**Section D-1.3**

Staff nurses will perform appropriate actions to implement the guidelines for the school health program as outlined in the Texas Administrative Code §85.41 (see Section BB).

Continuing education and professional growth should be an integral part of planning by the individual school nurse and by the administrators of the school health program. Staff nurses may elect to move toward the professional goal of the expanded role of a school nurse practitioner.

Criteria

- Education: registered professional nurse with academic preparation at the diploma, associate degree, or baccalaureate level; current Texas license issued by Board of Nurse Examiners.
- Certification: see Section D-2.0
- Experience: Applicant from two year or three year programs should have supplemented basic preparation with a minimum of two years supervised nurse practice prior to entry into school nursing, preferably in Community Health.

Functions

- Serve as a health advocate for the child.
- Assess student health needs.
- Assume responsibility for management and planning for acute, chronic, and emergency health problems including appropriate referral and follow-through.
- Provide relevant counseling and guidance to assist children and parents in assuming responsibility for health maintenance of the child.
- Assist in communicable disease control through implementation of programs for student immunization, management of suspected and diagnosed cases of infectious disease, detection and control of pediculosis, scalp ringworm, impetigo and other scalp and skin conditions, and through venereal disease control information and referrals.
- Possess full range of knowledge and skills in health appraisals for identifying student health defects.
- Maintain accurate updated records of health information on all students, and make provisions for timely and accurate management of incoming and outgoing records and reports.
- Initiate referral and follow-up relevant to unmet health needs of students, and make appropriate interpretation and distribution of health information to facilitate identification of educational needs of students.
- Coordinate health service activities with the instructional program.
- Work with parents and with medical and health care community to promote optimum delivery of health care services to students.
- Anticipate supply and equipment needs appropriate to maintaining a continuous functional building level program.
- Participate in faculty activities.
- Allocate appropriate job functions and assume responsibility for supervision of nurse-extenders.

Nurse Extenders**Section D-1.4**

Nurse extenders, such as licensed vocational nurses, nurse aides, or volunteers, are non-professional employees with technical skills. Extenders may provide vital assistance to the school nurse by assuming routine record keeping activities and minor first aid.

There are selected activities and responsibilities which the nurse extender may fulfill to the benefit of the school health program. Nurse extenders are analogous to teacher aides and should not be expected to provide primary health service.

Licensed Vocational Nurse and/or Nurse Aide**Section D-1.41****Criteria**

- Education: high school graduate or GED
- Certification: Texas Education Agency paraprofessional
- LVN: current Texas license issued by the Board of Vocational Nurse Examiners
- Experience: Suggested is a minimum of one year's experience in some phase of community health, which includes contact with school-age children. A basic first aid course and cardiopulmonary resuscitation course should be acquired.

Functions

- Work under the immediate guidance and supervision of the school nurse.
- Has no responsibility as the sole health program provider, and should not be asked to provide health teaching, planning, nor implementing of the school health program.
- Assist with screening activities such as height/weight, vision, hearing, or scalp. All vision and hearing screeners must comply with Texas Department of Health requirements for tester training.
- Fulfill task-oriented role dealing with record keeping and paperwork.

Volunteer/Adult and Student Assistant**Section D-1.42**

The adult volunteer and the student assistant function in a nurse-supervised team structure. Task-oriented functions assigned by the nurse may be in keeping with the wide range of background knowledge and skills represented by persons serving in this capacity.

The Red Cross "Health Room Volunteer Program" is an example of a formal preparation that may be provided for volunteers. Orientation and continuing education for the volunteer is essential.

Adult and student volunteers should not have access to student records.

School Nurse Certification Texas Education Agency

Section D-2.0

A school nurse is not required to hold a Texas School Nurse certificate. However, the following Texas Education Agency certification is available.

1. Requirements for Provisional Certification of School Nurse with Bachelor's Degree:
 - a. bachelor's degree
 - b. current registration with Texas State Board of Nurse Examiners
 - c. satisfactory completion of course or certification examinations in federal and Texas constitutions
 - d. satisfactory completion of six semester hours in American History
 - e. submission of application with official transcripts showing a bachelor's degree conferred, photostatic copy of current registration with the State Board of Nurse Examiners, and \$10.00 fee (money order or cashier's check) to the Division of Teacher Certification
2. Requirements for Provisional Certification for Non-Degreed Registered Nurses:
 - a. current registration with Texas State Board of Nurse Examiners
 - b. satisfactory completion of course(s) or certification examination(s) in federal and Texas constitutions
 - c. submission of an application with official transcript or examination score, photostatic copy of current registration with the State Board of Nurse Examiners, \$10.00 fee (money order or cashier's check) to the Division of Teacher Certification
3. An individual who has a current registration with Texas State Board of Nurse Examiners may be employed in a school district as a school nurse without a provisional certificate.

School Nurse Evaluation

Section D-3.0

The primary objective of school nursing services is to strengthen the educational process through the school health program. It is imperative that nursing responsibilities in the promotion and preservation of optimum health be established, competencies and professional growth be provided through staff development, and evaluation guidelines be written and understood.

School nurses are included in TEC §21.201, provided in Section BB-7.0, and defined as "Teacher means... full-time professional employee and are to be evaluated annually." Additionally, evaluation is addressed in TEC §21.913 outlining the "Duties of Public School Principal."

- (a) Public school principals, who shall hold valid administrative certificates, shall be responsible for:
 - (1) assuming administrative responsibility and instructional leadership, under the supervision of the superintendent, for discipline, and the planning, operation, supervision, and evaluation of the educational program of the membership area in which he is assigned;
 - (2) submitting recommendations to the superintendent concerning assignment, evaluation, promotion, and dismissal of all personnel assigned to the membership center; and
 - (3) performing any other duties assigned by the superintendent pursuant to school board policy.
- (b) Nothing herein shall be construed as a limitation on the powers, responsibilities, and obligations of the school board as now prescribed by law.

Two school nurse evaluation samples are provided in the following sections, D-3.1 and D-3.2. School districts are encouraged to make additions or deletions to these instruments to meet specific needs.



Section D-3.1

Healthy Independent School District

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

Healthy, Texas

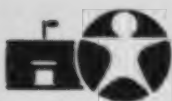
School Nurse Evaluation Form

(Sample 1)

- *O = Outstanding— Performance as observed is consistently exceptional and is worthy of special recognition.
- C = Competent— Performance as observed is professionally competent and meets expectations of HISD.
- N = Needs Improvement— Performance as observed indicates a need for continued growth and improvement is expected.
- *U = Unacceptable— Performance as observed does not meet the standards of HISD and improvement is mandatory.

*Comments must be recorded.

Performance Competencies	O	C	N	U	Comments
1.00 Personal-Professional Characteristics					
1.01 Fulfills professional role expectations with minimal personal interest/family conflict.					
1.02 Reflects professional leadership abilities in responsible self directed goal setting, decision making, and action taking activities.					
1.03 Exercises professional judgment in absences from work.					
1.04 Participates in self-directed continuing learning activities in acquiring new skills and knowledge for upgrading school nursing.					
2.00 Health Clinic Management					
2.01 Maintains a safe, orderly, and attractive work area with appropriate emotional and physical environment.					
2.02 Develops a program that assures safe ongoing emergency health care.					
2.03 Anticipates supply and equipment needs for maintaining and continuous school health program.					
2.04 Develops a complete and functioning health program through maximum utilization of existing facilities.					
2.05 Plans for communication with principals and faculties to provide a health program with minimal interruption to total building schedule.					
2.06 Maintains accurate and current health information on all students to insure the timely management of incoming and outgoing records and reports.					
2.07 Initiates referrals and follow-up relevant to the unmet health needs.					
2.08 Makes appropriate distribution of health information to facilitate recommended changes in academic schedules.					
3.00 Interacting With Students					
3.01 Provides opportunities for developing self-evaluation skills which aid the student in setting realistic goals and understanding himself, his strengths, and his limitations.					
3.02 Assists the student in accepting responsibility for his actions.					



Performance Competencies		O	C	N	U	Comments
3.03	Demonstrates respect for students by showing tolerance for students whose ideas differ; using supportive criticism rather than blame, shame, or sarcasm; encouraging students to respect the rights of others; being fair, impartial and objective in the treatment of students.					
3.04	Provides opportunities for all students to experience success by recognizing the special needs of students.					
3.05	Utilizes appropriate district services available to benefit the student.					
3.06	Sets an example of, and encourages, socially acceptable behavior.					
3.07	Maintains an atmosphere conducive to freedom of thought and expression and shows respect for pupil opinions and suggestions.					
3.08	Readily available to students for counseling and individual help.					
4.00	Professional Attitude and Conduct					
4.01	Shows an honest, caring attitude that invites student trust.					
4.02	Demonstrates the ability to see student as a total person rather than a physical, educational or social problem.					
4.03	Uses resourcefulness and skill in helping students with health maintenance needs and with management of health problems.					
4.04	Respects the need to treat personal health problems as a very private affair.					
5.00	Skills and Knowledge					
5.01	Demonstrates knowledge and skills in health appraisal techniques.					
5.02	Utilizes appropriate resources within the community to promote delivery of health care services.					
5.03	Serves as a leader in school community activities for communicable disease control, preschool health screening, health room volunteer services, etc.					
5.04	Demonstrates a sensitivity to students' need to be heard as well as helped by health counseling.					
5.05	Interprets and uses health information with good judgement.					
5.06	Helps students and parents in exploring alternate approaches to meeting health care needs.					
5.07	Provides a helping relationship with individuals or families in crises intervention.					
5.08	Participates in teacher-nurse-family conferences at appropriate times to consider the physical, emotional, and social health of each child.					
6.00	Health Education Skills					
6.01	Uses health services activities as a vehicle for direct and indirect health teaching.					
6.02	Serves as a resource person to the school staff in special areas of expertise.					
6.03	Involves appropriate resource persons from the health-medical community in the educational process.					
6.04	Provide learning experiences to equip students to make constructive decisions regarding health behavior.					
6.05	Serves as an extension to career education efforts through participation in the area of health career guidance.					



Performance Competencies	O	C	N	U	Comments
7.00 Interacting With Parents and Community					
7.01 Contributes to establishing and maintaining a positive school-community relationship.					
7.02 Participates in an active role with health, welfare, and community activities.					
7.03 Conducts the school health program in a manner that elicits positive support from students, parents, school and community.					
7.04 Communicates an interest in community health through creative participation.					
7.05 Recognizes that the parent is an extension of the school health program and invites parental involvement in planning health care.					
8.00 Appearance and Health					
8.01 Keeps grooming and personal attire appropriate to professional health services practice.					
8.02 Increases the positive image of school health programs through the practice of good health habits.					
8.03 Maintains stability and poise in student, parent and peer group relationships.					
8.04 Demonstrates enthusiasm and vitality in the performance of duties.					



Healthy Independent School District

Healthy, Texas

- HEALTH SERVICES
- HEALTH EDUCATION
- SCHOOL ENVIRONMENT

School Nurse Evaluation Form (Sample 2)

Rating Scale for Evaluation:

Unacceptable		Acceptable		Outstanding	
0	35	36	61	62	81

0 - 35: Unacceptable
 36 - 61: Acceptable
 62 - 81: Outstanding

Breakdown of Areas of School Nurse Competencies And Value for Each Performance Descriptor:

Area of School Nurse Competence	Unacceptable	Acceptable	Outstanding
	Competencies Performed	Competencies Performed	Competencies Performed
#1	1-8	9-11	12-13
#2	1-10	11-14	15-17
#3	1-3	4-5	6-7
#4	1	2-4	5-6
#5	1-4	5-7	8-10
#6	1-4	5-7	8-9
#7	1-2	3-5	6-7
#8	1	2	3-4
#9	1	2-3	4
#10	1	2-3	4



School Nurse Evaluation Form

#1: Responsibility to the School Staff

The school nurse is an essential member of the professional staff employed to assist in the implementation of the basic goals of education. As a professional staff member, the nurse:

- Implements the school health program and practices in accordance with the school district's philosophy of education.
- Adapts the guidelines, as stated in the district's school nurse policy and procedure book, to the needs of the students, staff, and community.
- Serves as a contributing member on a committee to establish or revise school district policies.
- Implements and is knowledgeable of applicable state and county school laws, regulations, and recommendations.
- Discusses school health legal provisions with the school principal.
- Establishes a channel to communicate health trends and problems to the school principal and faculty.
- Keeps abreast of current developments within the total school district program.
- Explains to parents the school and district educational philosophy.
- Actively participates in faculty meetings and serves on faculty committees.
- Regularly attends parent-teacher association meetings and participates in activities.
- Establishes an effective relationship with all school personnel.
- Submits reports to the appropriate personnel on time.
- Creates a climate which encourages staff members to seek the nurse's counsel.

#2: Health Appraisal

Health appraisal is the sum total of all diagnoses and observations made concerning the health status of the school child. The school nurse:

- Plans and implements health assessment and screening programs with assistance from school personnel and parent groups.
- Sets priorities as to which student will be appraised.
- Schedules the frequency of health assessments necessary for the school.
- Conducts screening programs such as:
 - Communicable disease
 - Vision
 - Hearing
 - Dental
 - Special (Laboratory)
 - Scoliosis
 - Hypertension
 - Physical fitness
 - Other
- Provides information to parents and school personnel that will assist with evaluation of students' health needs.
- Records data from health assessment, screening programs, corrections, and follow-up procedures on forms approved for use in the school.

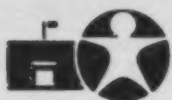


- Utilizes information gathered from the health assessment and screening programs to:
 - Identify health problems.
 - Interpret rules and regulations in regard to conditions under which students are excluded and readmitted to school.
 - Serve as a resource for health education curricula.
- Assists parents in obtaining professional services for children needing corrections.
- Interprets and/or reinforces through counseling procedures with student and parent, the physician's findings and recommendations.
- Utilizes community, state, and national resources in referral of health problems.
- Utilizes a system of periodic review and supervision of all students' health status.
- Develops and utilizes a variety of instruments suitable for review by the nurse, student, teacher, and parent as follows:
 - Observation
 - Interviews and conferences
 - Questionnaires
 - Checklists
 - Surveys
 - Records
 - Reports
 - Tests
- Records corrections, notes on referrals, health counseling, and follow-up procedures.
- Files all health records to be available for future use.
- Submits reports of health assessment and screening programs to supervisory staff and principal.
- Reviews stated aims and objectives of the health appraisal and screening program to determine if these have been accomplished.
- Revises as needed the current health assessment and screening program.

#3: Health Counseling

Health counseling is an essential part of school nursing services. The school nurse:

- Establishes and implements methods of identifying students and families who need health counseling.
- Plans and schedules health counseling sessions for individuals and groups.
- Utilizes each opportunity to do circumstance-oriented health counseling.
- Obtains all information from appropriate personnel and records prior to health counseling sessions.
- Informs appropriate personnel of counseling progress.
- Utilizes all appropriate school and community services to effect necessary behavioral change of students and families.
- Periodically reviews the progress of counseling.

**#4: Special Education Program**

The school nurse's specialized knowledge enables the nurse to assist in planning educational services appropriate for students whose physical, mental, and social deviations have educationally significant dimensions. The school nurse:

- Assists teachers in identifying candidates for possible placement in special programs.
- Follows school district procedures to secure all necessary data needed for evaluation of candidates for admission or dismissal.
- Conveys the philosophy of special education to students and parents during health counseling sessions.
- Participates in re-evaluation of students in special education each year.
- Recommends modification in the health education program to the special education teachers to meet the needs of the students.
- Conducts inservice education programs indicated by the number and types of referrals from the school personnel.

#5: Communicable Disease Prevention and Control Program

The school nurse holds the primary responsibility for implementing the control of communicable disease in the school for the protection of all students and school personnel, in compliance with the rules and regulations established by the local and state health departments. The school nurse:

- Maintains and monitors students' immunization records to ensure compliance with communicable disease laws, regulations, and policies of the State and local school district.
- Interprets these laws, regulations, and policies to the parents and students.
- Cooperates with local health department in conducting communicable disease control program.
- Assists teachers in developing a unit on communicable disease.
- Makes specific recommendations to appropriate persons, i.e., possible need for tetanus booster following injury.
- Assists in enforcing policies for the control of communicable disease for students and school personnel by:
 - Exclusion
 - Readmission
 - Classroom inspection when necessary
 - Reporting to health department if necessary
- Communicates with faculty regarding current communicable disease problems.
- Plans, organizes, and assists with the control programs when necessary.
- Supervises the reporting of all animal bites to the appropriate official agency.
- Identifies signs and symptoms of communicable diseases present in the community.

#6: Environmental Health and Accident Prevention

The school nurse is the key person in ascertaining problem areas and channeling information to the appropriate authority for evaluation and corrective action. The school nurse:

- Inspects school plant at periodic intervals for environmental health problems and reports such problems to the appropriate person.



- Complies with first aid guidelines when administering first aid and emergency care.
- Attends periodic first aid refresher courses.
- Provides first aid supplies.
- Plans with the building administrator for emergency care.
- Provides emergency care instruction to school personnel.
- Reports accidents to appropriate personnel for corrective action.
- Analyzes the compiled statistical reports to determine causes and location of accidents.
- Initiates safety programs:
 - As results of above reports
 - Preventive

#7: Health Education

Health education includes all information relating to health in the home, school, and community. Functional health education must be more than a subject in the curriculum. It must be action-centered and behavior-changing if it is to serve the needs of students. It is impossible to separate health education from health service. The school nurse is involved in instruction as a health specialist. The school nurse often:

- Serves on a curriculum development committee as a health specialist.
- Accepts invitations from teachers to participate in classroom activities as a health resource person for a variety of topics.
- Disseminates current and scientifically accurate health education materials and information to teachers.
- Compiles profile of current school and community health problems to be used in determining health curriculum content.
- Reviews with appropriate personnel current publications and other media being considered for use in the curriculum.
- Serves as resource speaker and consultant at PTA, parent education meetings, discussion groups in special interest areas, and pre-school orientation.
- Utilizes opportunities to informally share with parents health information which will effect positive attitudes and behavior.

#8: School-Community Health Program

The school nurse should exercise leadership in assuring that the school health program is an intergral part of the community health program. The school nurse:

- Promotes communication between the community health professionals and the school.
- Maintains current files of community resources.
- Utilizes the services of health or community agencies.
- Participates in the implementation of community health programs.

**#9: School Nursing Service Evaluation Program**

Program evaluation should be designed to reveal both strengths and weaknesses in the school nursing service program. It should reveal existing opportunities for more effective procedures and practices; and it should provide data which can be used to revise specific objectives, improve methods and materials, and develop new learning experiences. The school nurse:

- Compiles and analyzes school health department records, reports, and statistical information at least twice yearly.
- Plans and implements action (projects) research as needed to improve the school nurse service program.
- Reviews published research and applies findings if appropriate.
- Conducts self-evaluation yearly using a professionally prepared instrument.

#10: Responsibility to the Profession

School nursing is unique in that it requires skills and knowledge derived from two professions, nursing and education. The school nurse serves as a faculty member with the same obligations as other teachers to participate in activities of the education profession. The school nurse :

- Joins and participates in activities of school nurse and teacher professional organization.
- Sustains current health knowledge and trends by:
 - Reading professional literature
 - Attending lectures or workshops
- Attends and participates in school and community activities.
- Informs students regarding career opportunities in health professions at the end of each unit of health.

Section E

Responsibility of the School Nurse

- | | |
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| Section E | <p>Responsibility of the School Nurse</p> <ul style="list-style-type: none">1.0 National Association of School Nurses, Statement2.0 Disaster Guidelines3.0 Emergency and Illness Care<ul style="list-style-type: none">3.1 Report of Eye Injury3.2 Recommendation Regarding Medication4.0 Communicable Disease Control<ul style="list-style-type: none">4.1 Communicable Disease Chart5.0 Immunizations<ul style="list-style-type: none">5.1 Sample 1: Key punch Form5.2 Sample 2: Key punch Form5.3 Suggested Schedule for Routine Immunizations—Texas Department of Health5.4 Annual Report of Immunization Status Form5.5 Personal Immunization Record6.0 Reportable Diseases of Texas<ul style="list-style-type: none">6.1 Reportable Diseases of Texas (List)7.0 Child Abuse<ul style="list-style-type: none">7.1 Report of Child Abuse or Neglect8.0 Suicide<ul style="list-style-type: none">8.1 Facts and Fables on Suicide8.2 Warning Signs of Suicide |
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**National Association
Of School Nurses, Statement
The School Nurse Services Program**

Section E-1.0

GOAL: To strengthen the educational process through improvement of the health status and learning of children and youth.

I. Responsibility to the School Staff

GOAL: To function as a contributing member of the school staff in all aspects of the school program.

II. Health Assessment

GOAL: To assess and evaluate the total health and developmental status of each student through nursing assessment and the use of appropriate evaluative techniques.

III. Medication in the Schools

GOAL: To assure the school attendance for children who must use medication in the treatment of chronic disabilities or illness.

IV. Health Counseling

GOAL: To assist students, parents, and teachers to obtain optimum wellness by stimulating behavior change through individual and group health counseling.

V. Special Education Responsibilities

GOAL: To assist in the appropriate placement of students with exceptional needs.

VI. Responsibilities to Students with Chronic Health Problems

GOAL: To assist students, parents, and teachers to adapt to students' chronic health problems.

VII. Responsibilities to Students With Special Needs

GOAL: To protect the well-being of children and youth.

VIII. Responsibilities Related to Nutrition of Students

GOAL: To assure a well-nourished school population.

IX. Prevention and Control of Communicable Disease

GOAL: To protect the well-being of students.

X. Emergency Care Responsibilities

GOAL: To set and maintain standards of emergency care to minimize the effects of accidents and illness in the school.

XI. Health Instruction

GOAL: To assure that each student will be a health-educated person and a knowledgeable health consumer.

XII. Nurse Practitioner in the Schools

GOAL: To provide quality indepth physical assessment to students and to improve the delivery of health care.

XIII. School Health Liaison to Community Agencies and Medical Care Facilities

GOAL: To assure that the health needs of the school population are considered in the community's overall health planning.

XIV. Research

GOAL: To improve the School Nursing Service Program.

XV. Program Evaluation

GOAL: To improve the School Nursing Services and Educational Programs.

XVI. Responsibilities to the Profession of School Nursing

GOAL: To contribute to the improvement of the profession and to maintain personal professional competence.

Disaster Guidelines

Section E-2.0

The building principal is directly responsible for emergency care of students and employees in the event of a disaster. Students and staff should be familiar with disaster plans through well organized and practiced drills. The school nurse or a principal's designee will provide care of the ill and/or injured following a disaster until students may be released to the care of parents/guardians.

Disaster Nursing

The school nurse or a principal's designee will immediately—by telephone, short wave radio, or whatever means available—notify an immediate supervisor who will alert other persons and agencies needed. All emergency and rescue efforts are coordinated through the local chapter of the American Red Cross and the local Civil Defense headquarters. Follow-up reports are made by the nurse as the situation develops or is further assessed.

The on-site nurse in charge may be required to assist in setting up shelters, emergency aid stations, temporary infirmaries, and morgues.

Nurse Responsibilities

- Establish nursing care priorities.
- Plan for adequate emergency communication and transportation; request additional professional personnel.
- Assign nurses and other health service personnel to appropriate duties.
- Set up a triage station.
- Arrange for necessary medical and nursing supplies.
- Arrange for appropriate transfer or referral of patients to follow-up health care and other facilities.
- Maintain records of patients treated, referred, or transferred.
- Maintain adequate sanitation.
- Exercise professional judgement at all times.
- See that all persons seeking care are received with genuine reassurance, given prompt treatment, and understand any instructions for continuing treatment.

Emergency and Illness Care

Section E-3.0

Each school district should have comprehensive, written emergency and illness care policies. The policies should be approved by school administration, board of trustees, and nurse(s). Policies should be stated in a procedure manual. The school is responsible for the immediate handling of accidents and sudden illness occurring on school property or during school sponsored activities. The school is not responsible for treatment or medical expense incurred after the administration of first aid.

Recommendations

- Emergency cards should include: telephone numbers where parents/guardians may be reached during the day; other persons in the community to be called if parents cannot be located; local physician's name and telephone number; local hospital preference; any medical problems or drug allergies which the student may have; and a parental signature. (see Section CC-4.0)
- The nurse and/or other designated school personnel, with the emergency card, accompany the student to the hospital and remain until the parent/guardian assumes responsibility. If a private car is used, two adults should be assigned, allowing one person to attend the student.
- Ambulance, police, fire departments, and poison control center phone numbers should be posted conspicuously and reviewed annually with staff members.
- Arrangements should be made, in cooperation with the principal, for another qualified person to administer first aid in the nurse's absence.
- The school should provide a health room/clinic and appropriate first aid supplies.
- First aid in the schools should be administered in accordance with accepted procedures, such as those of the American Red Cross. A current first aid manual should be kept in the health room/clinic for quick reference.
- The school nurse should be qualified as a certified First Aid and Cardiopulmonary Resuscitation Instructor. First aid and CPR classes should be offered to school personnel and students on a regular schedule.
- All first aid procedures should be reviewed annually.
- All *animal* bites should be reported to the proper authorities after emergency care is given. (see Section CC-7.0).
- All incidents involving a *head injury* should be carefully documented. A parent/guardian of the student sustaining the head injury should be notified immediately. Head injury symptoms may not manifest at once, and parents must be made aware of later evolving signs and symptoms (see Section CC-6.0).
- All shop or lab-related incidents involving *eye injury* to student or personnel must be reported to the building principal. The "Report of Eye Injury" form, TEA ADM-062R81, follows (see Section E-3.1).
- All medication must be administered within the guidelines of TEC §21.914, included in Section BB.

Section E-3.1

District Name _____

TEXAS EDUCATION AGENCY
Division of Curriculum Development
Report of Eye Injury

Co.-Dist. # _____

School Name _____

Authority for Data Collection: Texas Education Code, Section 21.909 part (d)**Planned Use of the Data:** Establish preventive standards for schools, and development of safety education curriculum.**Instructions:** Please prepare within five days of the eye injury and forward to the Texas Education Agency. Contact Glenn Peavy at (512) 475-2608 if further clarification is needed.

1. Name of injured _____
() Pupil
() Teacher
() Other (_____)
2. Sex _____ Age _____ Grade or Position _____
3. Date of Accident _____ Time of Day _____
4. Time lost Due to Accident _____
5. Location of Accident: School _____ Facility _____
6. Course Being Taught _____
7. Activity in Class _____
8. Was Activity Supervised? _____ Yes _____ No
9. Name of Supervisor or Teacher _____
10. Nature and Extent of Injury _____

11. Cause of Accident _____
12. Were Protective Eye Devices Worn? _____ Yes _____ No

Typed Name of Authorized School Official	Telephone	Date
--	-----------	------

Signature of Authorized School Official _____

Return completed report to:
Texas Education Agency
Safety & Driver Education
Division of Curriculum Development
201 East 11th Street
Austin, Texas 78701

ADM-062R81

Recommendation Regarding Medication

Section E-3.2

It is recommended that school districts *not provide* any medication for students or personnel. Only medication provided by and requested by a parent/guardian should be dispensed.

If medication is provided, school districts and school nurses will be in the position of not only "diagnosing and prescribing," but also in "dispensing" medication for which neither is licensed.

"Medication" is recognized as prescription as well as nonprescription drugs and includes, but is not limited to: analgesics, antipyretics, antacids, antibiotic ointments, antihistamines, decongestants, or cough/cold preparations.

Communicable Disease Control

Section E-4.0

The school nurse should assume a leadership role in establishing a communicable disease control program in the school. The nurse works with the superintendent, principal, and teachers to develop written recommendations concerning:

- Exclusion and readmission of children with suspected communicable disease.
- Enforcement of the statutes regarding immunization for school attendance.
- Establishment of policies for handling children suspected of having communicable diseases.
- Investigation to determine whether the school is the source of epidemics of communicable diseases.

The nurse should be aware of all current communicable disease regulations. If the nurse is not in the school on a daily basis, the staff member responsible for exclusions and readmissions should be kept informed of current regulations. The nurse also helps teachers develop skills in observing symptoms which might indicate the onset of an acute communicable disease.

Working With Parents or in the Home, the Nurse

- Acts as a guest in the home.
- Tries to increase parents' understanding of the needs for communicable disease control.
- Encourages parents to keep children at home and under observation when acute symptoms appear. If a communicable disease develops, children should stay at home until recovery is complete.
- Gives information to increase skills in avoiding exposure to communicable disease.
- Encourages vaccination and immunization for children.
- Demonstrates nursing care, isolation techniques, and effective handwashing techniques.
- Discusses regulations governing contacts, food handling, or other possible dangers of spreading disease.
- Provides appropriately written instructions and/or leaflets, and discusses control measures for particular diseases.
- Outlines plans for the child's return to school.

Working With the Community, the Nurse

- Encourages programs that provide for immunization of all children in the community through either private physicians or public clinics.

The rules and regulations concerning communicable disease control, established by the Texas Department of Health, are provided in Section BB.

COMMUNICABLE DISEASE CHART

DISEASE	INCUBATION PERIOD	EARLY SIGNS OF ILLNESS	ISOLATION	NOTES
Athlete's Foot	Unknown	Blisters and cracking of the skin of the feet, usually between the toes.	Not excluded from school. Suspected cases should be excluded from gymnasiums, swimming pools, and activities likely to lead to exposure of others.	Teach importance of hygienic care. Refer to private physician or Health Department.
Chickenpox	2 to 3 weeks	Slight fever, fine blisters appear first on scalp, then on face and body. Successive crops of blisters remain 3-4 days, leaving scars.	Six days after last crop of blisters appear.	No vaccine available. Consult your physician.
Common Cold	12 to 72 hrs. Usually 24 hrs.	Runny nose, watery eyes, chilliness and malaise. Usually no fever, unless complications have developed.	Until clinical recovery.	
Diphtheria	2-5 days, occasionally longer	Sore throat, fever, the symptoms rapidly become more severe.	Until two cultures from both nose and throat, taken after cessation of antimicrobial therapy and not less than 24 hours apart, fail to yield diphtheria bacilli.	Vaccine available. Consult your physician or Health Department.
Epidemic Meningitis	Varies from 2-10 days. Commonly 3-4 days	Sudden onset of headache, fever, nausea and often vomiting, stiff neck. Frequently a fine spotted rash appears.	Exclude from school until released by private physician or Health Department.	Consult your physician.
Head Lice (Pediculosis)	Eggs hatch in a week; reach sexual maturity in about 2 wks.	Excessive scratching of head. White egg (nit) on hair that will not flick off.	Exclude until under treatment.	Refer to private physician or Health Department.
Viral Hepatitis A. Infectious	From 15 to 50 days. Usually 25 days.	Nausea, vomiting, extreme fatigue, often pain in upper abdomen followed by jaundice. Mild cases occur without jaundice in children.	Exclude from school until released by private physician or Health Department.	Supervised handwashing after using the toilet and before meals will help control spread. Personal hygiene is emphasized. See your physician.
B. Serum	45-160 days Average 60-90 days.	Masked onset, loss of appetite, vague abdominal discomfort, nausea, vomiting, often progressing to jaundice.	Exclude from school until released from medical supervision.	
Impetigo	Variable	Small blisters on the skin which later become crusted and contain pus.	Permit school attendance if under adequate treatment.	Refer to private physician or Health Department.
Influenza	24-72 hrs.	Rapid onset with fever, chills, headache, lack of energy, muscle aching, sore throat, cough.	Until clinical recovery.	
Measles— Rubeola	7 to 14 days	Runny nose, watery eyes, fever, cough. Blotchy rash appears 4th day.	During catarrhal state and for 7 days after appearance of rash.	Vaccine available. Consult your physician or Health Department.
German Measles— Rubella	14 to 21 days	Slight head cold. Swollen, tender glands at back of neck. Changeable rash.	Until clinical recovery.	Vaccine available. Consult your physician or Health Department.
Mumps	12 to 26 days	Pain in cheeks, increased by chewing. Swelling over the jaw and in front of ear.	Until swelling disappears.	Vaccine available. See your physician.
Pink Eye— Conjunctivitis	Usually 24 to 72 hrs.	Red eyes, discharge from eyes, crusted lids.	Exclude until released by private physician.	Consult your physician.
Poliomyelitis	Commonly 7-12 days with a range from 3-21 days	Fever, headache, malaise, gastrointestinal disturbance, stiffness of the neck and back. Often followed by paralysis.	Exclude from school until released by physician or Health Department.	Can be prevented by vaccination. See your physician or Health Department.

Communicable Disease Chart

Section E-4.1

Responsibility of the School Nurse

July 1983

Section E

Rickettsial Disease A. Rocky Mtn. Spotted Fever	3 to 10 days	Sudden onset, moderate to high fever, ordinarily persisting 2-3 wks., headaches, chills, redness of eyes. Raised rash on extremities progressing to palms and soles.	Not necessary.	Transmitted by tick bites. Not directly communicable from man to man.
B. Typhus	1 to 2 wks.	Headaches, chills, lack of energy, fever, achse, raised rash appearing on the 5th or 6th day.	Not necessary.	Transmitted by flea bites. Not directly communicable from man to man.
Ringworm of the Body	4-10 days	Flat, spreading, scaly, ring-shaped spots. The margins are usually reddish and elevated.	Permit school attendance if under adequate treatment and sores are covered.	Refer to private physician or Health Department.
Ringworm of the Scalp	10-14 days	Flat spreading, ring-shaped bald spots on hairy parts of head.	Exclude unless under adequate treatment. Consult Health Department for current regulations.	Refer to private physician or Health Department.
Salmonellosis	6-72 hrs.	Sudden onset, abdominal pain, diarrhea, nausea, vomiting and fever.	Exclude until released by physician.	
Scabies	Several days or weeks	Small raised reddened areas or blisters with connecting grayish-white lines. Marked itching. Most commonly found in folds of the skin.	Exclude until under adequate treatment and no open lesions can be observed.	Refer to private physician or Health Department.
Shigellosis	1-7 days	Diarrhea, cramps, fever, vomiting.	Exclude from school until released by physician.	
Streptococcal Infections (including Scarlet Fever)	1-3 days	Fever, sore throat. Fine red rash over body for Scarlet Fever.	For at least 7 days from onset if untreated. With adequate medical treatment, 48 hrs.	No vaccine available. Consult your physician.
Tetanus	4 days to 3 weeks	Painful muscular contractions—primarily of the masseter (jaw) and neck muscles.	Not necessary.	Vaccine available. Consult physician or Health Department.
Tuberculosis	4-12 weeks from infection to demonstrable pulmonary lesion	Listlessness, loss of appetite, weight loss, low grade fever, positive tuberculin skin test.	Case: If proved to be noninfectious and physical condition permits, may attend school. Contacts: May attend school but should have TB skin tests. If positive, child should be referred to his family physician for further study.	If reactor prevalence is 1% or greater, recommend TB skin tests of 1st and 7th grade school children to identify Tuberculin reactors for referral to physician for further study.
Venereal Disease A. Gonorrhea	3-5 days	Male—Purulent urethral discharge; burning on urination; inflammation & swelling of genital region. Female—Possibly no symptoms; vaginal discharge, pain in abdomen (when salpingitis occurs).	Not necessary.	Refer to private physician or Health Department. National Venereal Disease Hotline— 1-800-227-8922 — Toll Free
B. Syphilis	21 days	1st sign—genital sore (5 week duration); 2nd sign—generalized rash, mucous patches, sore throat, headache, fever alopecia, etc. (7 weeks duration).	Not necessary.	Refer to private physician or Health Department. National Venereal Disease Hotline— 1-800-227-8922 — Toll Free
Whooping Cough Pertussis	7 to 10 days	Tight dry cough which becomes more severe. Cough, whoop, and vomit.	For 21 days after appearance of typical "whoop."	Vaccine available. Consult your physician or Health Department.

Immunizations

Section E-5.0

Immunization requirements are established by the Texas Department of Health. School districts are required by the State Board of Education to have written policies on immunization compliance standards for students. School nurses are usually the personnel assigned by school administrators to assure the students are in compliance.

Schools are required to keep careful immunization records on each student. Time spent on record keeping activities and parent/student contact regarding immunizations should be included on a suitable reporting form (see Section CC). High immunization protection levels and other appropriate communicable disease control measures can make a significant impact on a district's Average Daily Attendance (ADA).

Many school districts have computerized student immunization records and medical problem notations. Nurse extenders may assist the school nurse in keeping computer information up-to-date. The regional education service centers may help in the establishment of programs. Sample computer keypunch forms follow (see Sections E-5.1 and 5.2).

Section 2.09 of the Texas Education Code requires all students to be immunized against diphtheria, rubeola (measles), rubella, tetanus, and poliomyelitis. The Texas Department of Health is required to provide these immunizations in areas where local service is unavailable. The law further states that the Department of Health may modify or delete any of the required immunizations, or require immunization against additional diseases (i.e., mumps). Rules and regulations pertaining to provisional admission are also promulgated by the Health Department. Immunization laws are reprinted in Section BB of this handbook. A sample immunization card is included in Section E-5.5.

A "Suggested Schedule for Routine Immunizations" is provided in Section E-5.3. This schedule is compatible with recommendations from the American Academy of Pediatrics (AAP) and the Public Health Service Advisory Committee on Immunization Practices (ACIP). Such recommendations often call for a larger number of doses for immunization against diphtheria, tetanus, pertussis, and poliomyelitis.

Districts are required to submit a report of immunization status for students usually in December of each year. This report is developed jointly by the Texas Education Agency and the Texas Department of Health. The reporting forms are distributed by Texas Education Agency and are returned to the Agency (see form, Section E-5.4). Texas Department of Health compiles the reported data and publishes *Texas Public School Immunization Report*.

NOTE: Representatives of the Texas Department of Health and local health departments will, upon request, assist school administrators in meeting requirements of the law.

Section E-5.1

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Sample 2: Keypunch Form

Section E-5.2

RECORD OF IMMUNIZATIONS

Name _____		STUDENT IDENTIFICATION										Check Digit
		LOCATION			STUDENT NUMBER							
Grade _____	Sex _____	Adviser _____	1	2	3	4	5	6	7	8	9	0
Birth date _____			1	2	3	4	5	6	7	8	9	0
Parent/Guardian _____			1	2	3	4	5	6	7	8	9	0
Address _____			1	2	3	4	5	6	7	8	9	0
Zip Code _____	Telephone _____		1	2	3	4	5	6	7	8	9	0

DPT				DT				POLIO			
First	Second	Third	Booster	First	Second	Third	Booster	First	Second	Third	Booster
Mo	Year	Mo	Year	Mo	Year	Mo	Year	Mo	Year	Mo	Year
1	0	1	0	1	0	1	0	1	0	1	0
2	1	2	1	2	1	2	1	2	1	2	1
3	2	3	2	3	2	3	2	3	2	3	2
4	3	4	3	4	3	4	3	4	3	4	3
5	4	5	4	5	4	5	4	5	4	5	4
6	5	6	5	6	5	6	5	6	5	6	5
7	6	7	6	7	6	7	6	7	6	7	6
8	7	8	7	8	7	8	7	8	7	8	7
9	8	9	8	9	8	9	8	9	8	9	8
0	9	0	9	0	9	0	9	0	9	0	9
Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action	Re-action
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

Measles	Rubella	Mumps			
Mo	Year	Mo	Year	Mo	Year
1	0	1	0	1	0
2	1	2	1	2	1
3	2	3	2	3	2
4	3	4	3	4	3
5	4	5	4	5	4
6	5	6	5	6	5
7	6	7	6	7	6
8	7	8	7	8	7
9	8	9	8	9	8
0	9	0	9	0	9
Re-action	Re-action	Re-action			
YES	YES	YES			
NO	NO	NO			

LONG TERM MEDICATION	
YES	NO

TB SKIN TEST	
1st Grade	POS
7th Grade	NEG

EXCLUSION	
Medical	None

STUDENT MEDICAL INFORMATION		
	Yes	No
CONVULSIVE DISORDER		
VISUAL IMPAIRMENT		
SPEECH IMPAIRMENT		
HEARING IMPAIRMENT		
DIABETIC DISORDER		
ORTHOPEDIC DISORDER		
RHEUMATIC FEVER		
RESPIRATORY DISORDER		
OTHER IMP/DISORDER		

Suggested Schedule for Routine Immunizations Texas Department of Health

Section E-5.3

SUGGESTED SCHEDULE FOR ROUTINE IMMUNIZATIONS IN PUBLIC HEALTH CLINICS IN TEXAS

The following schedule and recommendations are compatible with those of the American Academy of Pediatrics (AAP) and the Public Health Service Advisory Committee on Immunization Practices (ACIP).

AGE	IMMUNIZING AGENTS	AGE	IMMUNIZING AGENTS
2 months	DTP, Trivalent OPV	12-18 month	DTP, Trivalent OPV
4 months	DTP, Trivalent OPV	4-6 years	DTP, Trivalent OPV
6 months	DTP, Trivalent OPV*	14-16 years	Td Adult
15 months	Measles, Mumps, Rubella	THEREAFTER	Td Adult every 10 years

*6-month OPV optional — see below.

BASIC IMMUNIZATIONS

Children and other young persons not previously immunized may be given basic immunizations at any age.

POLIO

Trivalent OPV is recommended:

Series begun under 1 year of age—two doses administered two months apart, plus a booster 6 to 12 months later and a final booster at 4-6 years of age. CAUTION: In those population groups where there is a significant risk of exposure to wild polio strains within those groups, an additional dose of OPV at 6 months of age should be considered.

Series begun at ages 1 through 17 years—two doses administered two months apart, plus a booster 6 to 12 months later. (And another at ages 4-6 years, for children completing series before the fourth birthday.)

Age 18 and above—routine immunization not recommended, except on an individualized basis due to increased risk.

Although other booster doses are not routinely recommended, an additional dose of trivalent OPV is indicated in the presence of poliomyelitis in the community, or before travel to endemic or epidemic areas. Salk polio vaccine is recommended for children (and their siblings) with immunodeficiencies, and for primary immunization of adults; see reverse for dosage.

DTP/Td ADULT

DTP may be used for either basic or booster immunizations through the age of six years. Individuals seven years of age and older should receive combined tetanus and diphtheria toxoids, Td (adult) in a series of two doses spaced 4 to 8 weeks apart, followed by a third, reinforcing dose 6 to 12 months later. A DTP booster is recommended at age 4-6 years, and Td boosters are recommended at age 14-16 years and every ten years thereafter.

MEASLES, MUMPS, AND RUBELLA VACCINES

Single-antigen measles vaccine should be given to infants as young as six months of age if there is likely exposure to natural measles prior to the recommended dose at age 15 months. Unless physician-diagnosed measles has occurred, or there is laboratory evidence of measles immunity, the following persons should be revaccinated with measles vaccine: (1) those vaccinated with live measles vaccine before 12 months of age; (2) those vaccinated at any age with inactivated vaccine (available from 1963 through 1967); (3) persons who are unaware of their age at vaccination; (4) those vaccinated prior to 1968 with a vaccine of unknown type; (5) persons immunized with live, further attenuated measles vaccine (e.g. Schwarz®, Moraten®, or unknown strains), along with immune serum globulin, regardless of age at time of vaccination; and, (6) those who received live measles vaccine within 3 months of inactivated measles vaccine.

Measles, mumps, and rubella vaccines may be administered to post-pubertal females only after interviews with qualified health clinic personnel have provided information that they are not pregnant and have been advised of the theoretical danger of concurrent vaccination and early pregnancy.

PREGNANCY

It is recommended that susceptible pregnant women be immunized against tetanus and diphtheria. Td (adult) is the recommended antigen and should be started as early as possible with two doses given 4 to 6 weeks apart. If the second dose is given during the first or second trimester, a third dose should be given about one month before term. Individuals previously fully immunized, but whose last dose was received 10 or more years ago, should be given a single dose of Td (adult) about one month prior to term.

LIVE VIRUS VACCINES WILL NOT BE ADMINISTERED TO PREGNANT WOMEN, OR WOMEN UNWILLING OR UNABLE TO PREVENT PREGNANCY DURING THE THREE MONTHS FOLLOWING IMMUNIZATION WITH LIVE VIRUS VACCINES. Non-immunized pregnant women who need immunization because of exposure to measles, rubella or poliomyelitis may, on the prescription of a physician, be immunized temporarily with immune serum globulin.

INTERRUPTION OF SCHEDULE

Delayed intervals between doses do not necessitate starting the series of inoculations over again.

SIMULTANEOUS ADMINISTRATION OF VACCINES

OPV, DTP/Td, and M-M-R vaccines may be administered simultaneously when there is doubt that the child will return for further doses.

PERSONAL IMMUNIZATION RECORDS

The Texas Department of Health will supply two forms that can be used to record immunization data: C-11 (Immunization Record, For Clinic Use, 3" x 5"), and C-102 (Personal Immunization Record, billfold size).

GENERAL

An interval of at least one month should be allowed between the administration of live virus vaccines, unless they are given simultaneously as mentioned above. When for any reason a tuberculin skin test is not administered simultaneously with live virus vaccines (including measles), the skin test should be administered and read either before, or at least thirty days after, the administration of live virus vaccines.

June 1982

(Back of Schedule)

IMMUNIZATION REFERENCE SCHEDULE

VACCINE	AGE		DOSAGE AND METHOD	SCHEDULE		REMARKS
	Minimum	Maximum		Vaccine	Boosters	
DTP	2 months	7th birthday	0.5cc Intramuscular	3 doses (1 or 2 month intervals)	6-12 mos. later Then after 4th birthday	See note 1
Td	7 years	NONE	0.5cc Intramuscular	2 doses (1 or 2 month intervals)	6-12 mos. later Then every 10 years	See note 1
Polio, oral	6 weeks	18th birthday	2 drops on sugar cube or on tongue	2 doses (optional 3rd dose at age 6 months)	6-12 mos. later and after 4th birthday	Live virus See notes 1, 2, 5
Measles	8 months	NONE	0.5cc Subcutaneous	1 dose	See note 3	Live virus See notes 3, 4, 5, 6
Mumps	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 4, 5, 6
Rubella	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 4, 5, 6
Measles-Rubella	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 3, 4, 5
Measles-Mumps-Rubella	12 months	NONE	0.5cc Subcutaneous	1 dose	NONE	Live virus See notes 3, 4, 5, 6
Polio, injectable	6 weeks	NONE	1.0cc Subcutaneous	3 doses at 1-2 mo. intervals, plus dose 6-12 mos. later	Every 5 years	See notes 1, 7

NOTES:

1. Delayed intervals between doses do not necessitate starting the series of inoculations over again.
2. Polio should be started at 6-8 weeks of age: 2 doses 2 months apart, optional 3rd dose at age 6 months, and boosters 6-12 months later and after 4th birthday. Polio for persons 1 thru 17 years: 2 doses 2 months apart and booster 6-12 months later, and after 4th birthday if applicable.
3. A physician-verified history or laboratory evidence of measles illness may be substituted for measles vaccine. Infants as young as six months of age should receive single-antigen measles vaccine if there is likely exposure to natural measles prior to the recommended 15-month dose. A measles booster is required for persons without physician-verified history or laboratory evidence of measles illness who received measles vaccine under the age of 12 months, as well as for persons previously immunized with inactivated (killed) measles vaccine.
4. Measles, mumps and rubella vaccines may be administered during the same clinic visit, using either combined M-R or M-M-R vaccines at one injection site, or monovalent vaccines at separate injection sites.

Measles, mumps, and rubella vaccines may be administered to post-pubertal females only after interviews with qualified health clinic personnel have provided information that they are not pregnant and have been advised of the theoretical danger of concurrent vaccination and early pregnancy.
5. An interval of at least one month should be allowed between the administration of live virus vaccines, unless they are given simultaneously as mentioned in number 4, above.
6. If a child from 12 to 15 months of age is seen in an immunization clinic, and there is doubt that the child will return for the scheduled dose of M-M-R vaccine at age 15 months, then M-M-R vaccine should be administered to the child while at the clinic. A later booster is not required.

If a clinic is temporarily out of stock of the appropriate single-antigen products, and if two of the three antigens in M-M-R are needed by a patient, it may be appropriate to administer M-M-R, unless there are contraindications to the individual antigenic components.

Histories of measles and mumps illnesses are not acceptable unless validated in writing by a physician, or confirmed by laboratory tests.
7. Injectable polio vaccine (IPV, Salk) is to be used only when oral polio vaccine is medically contraindicated. IPV can be administered during the same clinic visit as DTP/Td, provided separate injection sites are used. The dosage and method of administration above are for IPV vaccine manufactured by Connaught Laboratories, Ltd. Consult package insert for dosage and method of administration if another brand of IPV is being used.

Annual Report of Immunization Status Form

Section E-5.4

TEXAS EDUCATION AGENCY
Data Services Division

District Name _____

County-District No. _____

Annual Report of Immunization Status

Authority for Data Collection: Texas Education Code, Section 2.09 and 2.09a.**Planned Use of the Data:** To measure compliance with Section 2.09 and 2.09a, Texas Education Code and determine need for further immunizations.**Instructions:** Complete items below and on reverse side as applicable. Use the membership on the last day of the second six weeks reporting period. Contact Jerry Davis at (512) 475-6234 if help is needed in completing this form.

A. What was the total membership of the school district? Number _____		How many of the total membership have received 3 or more doses of DTP or Td, including at least one dose since the fourth birthday and within the last ten years? A dose received in the calendar month prior to, or of, the fourth birthday may be counted as a dose since the fourth birthday. Number _____ If this number is less than total membership, also complete item A on reverse.
B. How many of the total membership are under age 18? Number _____		How many under age 18 have received 3 or more doses of oral polio vaccine, including at least one dose since the fourth birthday? A dose received in the calendar month prior to, or of, the fourth birthday may be counted as a dose since the fourth birthday. Number _____ If this number is less than membership under age 18, also complete item B on reverse.
C. Same as total membership.		How many of the total membership have received at least one dose of measles vaccine on or after the first birthday, or during the calendar month of the first birthday and since January 1, 1968; or have provided a physician-validated history of measles illness? Number _____ If this number is less than total membership, also complete item C on reverse.
D. How many of the total membership are under age 12? Number _____		How many under age 12 have received at least one dose of rubella vaccine? Number _____ If this number is less than membership under age 12, also complete item D on reverse.
E. How many of the total membership are under age 11 as of September 1, 1982? Number _____		How many under age 11 have received at least one dose of mumps vaccine, or have a physician verified history of mumps illness? Number _____ If this number is less than membership under age 11, also complete item E on reverse.
Typed Name of Authorized School Official _____	Telephone _____	Date _____

Please return one copy, by December 15, 1982, to:
Texas Education Agency
Data Collection, Data Services Division
201 East 11th Street
Austin, Texas 78701

Signature of Authorized School Official _____

RES-016R83

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(Back of Form)

STUDENTS NOT COMPLETELY IMMUNIZED

- A. DIPHTHERIA/TETANUS: Number of students with
- | | |
|-------------------------------------|-------|
| Incomplete series (but on schedule) | _____ |
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | _____ |

Remarks:

- B. POLIO: Number of students with
- | | |
|-------------------------------------|-------|
| Incomplete series (but on schedule) | _____ |
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | _____ |

Remarks:

- C. MEASLES: Number of students with
- | | |
|------------------------|-------|
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | _____ |

Remarks:

- D. RUBELLA: Number of students with
- | | |
|------------------------|-------|
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | _____ |

Remarks:

- E. MUMPS: Number of students with
- | | |
|------------------------|-------|
| Medical Exemptions | _____ |
| Religious Exemptions | _____ |
| Provisional Enrollment | _____ |
| *Delinquent | _____ |

Remarks:

*PAST DUE FOR REQUIRED IMMUNIZATION(S)

Personal Immunization Record

Section E-5.5

VACCINES	DATE GIVEN	VALIDATION DOCTOR OR CLINIC
DTP or Td	1	
	2	
	3	
	4	
	5	
	6	
	7	
Polio ☐ Oral ☐ IPV	1	
	2	
	3	
	4	
	5	
Measles		
Mumps		
Rubella		
Other		
TO TEST	DATE	RESULT

PHYSICIAN'S VERIFICATION OF MEASLES/MUMPS ILLNESS

This is to verify that the person for whom this card was issued had:

- ☐ measles illness on or about _____ month and year
- ☐ mumps illness on or about _____ month and year
- and does not need the vaccine/s.

Date

Physician's Signature

THIS RECORD IS VALUABLE!

AN IMMUNIZATION RECORD IS REQUIRED WHEN ENTERING A CHILD CARE FACILITY OR SCHOOL IN TEXAS. DO NOT LOSE OR GIVE THIS RECORD AWAY.

SUGGESTED IMMUNIZATION SCHEDULE

AGE	VACCINES
2 months	DTP and Polio
4 months	DTP and Polio
6 months	DTP and Polio*
15 months	Measles, Mumps & Rubella
12-18 months	DTP and Polio
4-6 years	DTP and Polio
14-16 years	Td
Thereafter	Td every 10 years
*6 month polio dose optional	

YOUR PHYSICIAN MAY WISH TO CHANGE
THE ABOVE SCHEDULE

TEXAS DEPARTMENT OF HEALTH
Bureau of Communicable Disease Services

PERSONAL IMMUNIZATION RECORD

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

CLINIC APPOINTMENTS

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

TAKE THIS RECORD EACH TIME YOU VISIT YOUR PHYSICIAN OR CLINIC SO THAT DATES OF IMMUNIZATIONS CAN BE RECORDED



(1982)

Form No. C-102

Reportable Diseases of Texas**Section E-6.0**

Texas law requires that physicians report cases of communicable diseases to the local health departments, city or county health officers, or public health regional offices which will then transmit the information to the Texas Department of Health.

Any unusual or group expression of illness which may be of public health concern should also be reported to local health authorities or the state epidemiologist as quickly as possible (512/458-7207, or Tex-An: 512/824-9207).

Epidemiologic investigative consultation and assistance are available from the Texas Department of Health upon request.

Tuberculosis cases are reported individually on Tuberculosis Report Form, TB-15. Include name, address, birthdate, sex, race, and social security number, with pertinent information on the status of the disease.

Syphilis, Gonorrhea, Chancroid, Granuloma Inguinale, and Lymphogranuloma Venereum cases are reported individually on VD Report Card J-27, "Confidential Report of Venereal Disease," with pertinent information on the status of the disease being reported. Personal data required include name, address, sex, age, race, marital status, date of examination, treatment, and other specific information.

Reportable Diseases of Texas (List)

Section E-6.1

REPORTABLE DISEASES OF TEXAS

By virtue of the authority vested in the Board of Health by Articles 4418a and 4419, of the Texas Civil Statutes, certain rules and regulations have been established to control communicable diseases. The Board of Health has established methods of procedure in pursuance of Rules 1-33 of Article 4477 of the Texas Civil Statutes and has designated the following as reportable diseases in Texas:

Diseases to be Reported Immediately by
Telephone to the Texas Department of Health

Botulism	Plague	Smallpox
Cholera	Poliomyelitis, paralytic	Yellow fever
Diphtheria		

Diseases Reportable by Name, Address, Age, Sex, and Race/Ethnicity

Amebiasis	Leptospirosis	Rubella
Anthrax	Malaria	Rubella congenital syndrome
Aseptic meningitis	Measles	Salmonellosis
Botulism	Meningococcal infections	Shigellosis
Brucellosis	Mumps	Smallpox
Cholera	Pertussis	Tetanus
Diphtheria	Plague	Trichinosis
Encephalitis (specify etiology)	Poliomyelitis, paralytic	Tularemia
Hansen's disease (leprosy)	Psittacosis	Typhoid fever
Hepatitis, viral	Q fever	Typhus fever, endemic (murine)
Type A	Rabies in man	epidemic
Type B	Relapsing fever	Yellow fever
unspecified	Rheumatic fever, acute	
	Rocky Mountain spotted fever	

Diseases Reportable by Numerical Totals

Chickenpox	Streptococcal sore throat (including scarlet fever)
Influenza and flu-like illness	

Texas state law requires that physicians report cases of communicable diseases to the local health departments, city or county health officers, or Public Health Regional offices, who in turn transmit the reports to the Texas Department of Health.

In addition to the requirements of individual case reports, any unusual or group expression of illness which may be of public health concern should be reported to the local health authorities or the State Epidemiologist by the most expeditious means (AC 512) 458-7676 or STS 824-9676.

Epidemiologic investigative consultation and assistance are available from the Texas Department of Health upon request.

According to Rule b, Section .012 of the Rules and Regulations for the Control of Communicable Diseases, local school authorities shall report to the local health authority, those children attending school who are suspected of having a communicable disease or a disease requiring exclusion from school. Procedures for determining which children should be so suspected and reported, and for their exclusion from school pending appropriate medical diagnosis or recovery, shall be defined by the local health authority.

Bureau of Communicable Disease Services
Texas Department of Health

July 1980

Child Abuse

Section E-7.0

Child abuse is an extremely serious problem in our society. In 1981 there were 47,340 cases of suspected abuse and neglect reported to the Texas Department of Human Resources. During the year 1981, 110 children were known to have died from child abuse in the state. Increased public awareness has led to more cases being reported and more child abuse cases discovered. Health care providers should be acutely aware of the problem of child abuse.

The etiology of child abuse may have causal factors. The interrelationships between the child, parent, family, community, and society must be considered. Listed below are factors commonly associated with child abuse.

Factors Contributing to Child Abuse

By the Child:

- Prematurity, inadequate bonding to mother.
- Developmental or intellectual delay.
- Chronic or acute illness.
- Psychological problems.
- Product or unwanted pregnancy.
- Cause of financial burden.
- Behavior which provokes violence; actions to attract attention.

By the Parents:

- Use of violence to resolve conflicts.
- Psychological problems.
- Distorted expectancy of child; lack of knowledge of growth and development.
- Social isolation or rejection.
- Frustrated dependency needs.
- Power dominance of one parent over the other.
- Single parent home.
- High degree of stress.
- Lack of saleable job skills.

By Family:

- Unemployment.
- Inadequate housing.
- Loss of family member.
- Frequent relocation of residence.
- Social isolation or rejection by community.
- Lack of extended family support.

By Community:

- Environmental stress.
- Overcrowded neighborhoods.
- Isolation—non-supportive, geographic mobility.
- Lack of employment opportunities.
- Rejection of weak or dependent families.

By Society:

- Competition valued rather than cooperation.
- Physical force accepted as method of resolving conflict.
- Societal acceptance of corporal punishment.
- Violence depicted through media.

Usually child abuse is the result of a family crisis or series of crises with some triggering, stressful event. Schools may foster communication, coordination, and cooperation in the community to assist parents in learning how to deal with or resolve stress. The resolution almost always involves counseling for the entire family, not just the abusive person. Treatment generally requires a team effort, including numerous professionals: nurses, physicians, psychologists, social workers, educators, counselors, attorneys, and child care workers.

The task of determining whether a child has been physically, sexually, or emotionally abused is difficult. Even more of a dilemma occurs in trying to make a judgment regarding maltreatment or neglect. Cultural norms must be considered, though not used as an excuse or justification for maltreatment. Primary consideration must be for the health, welfare, and safety of the child.

The importance of documentation of suspected child abuse cannot be overemphasized. Along with the date, time, and name of the person notifying the nurse, both physical and emotional findings must be explicit and well-detailed. Do not rely on memory. Rather, keep a personal memorandum concerning each finding.

Notation Should Be Made As To

- When, where, and how did the "accident" occur?
- In what state of healing is the bruise, laceration, or burn?
- Size and shape of bruise, laceration, or burn.
- Does the mark(s) appear new or several days/months old?
- Are there other injuries in various stages of healing?
- What part of the body is affected?
- Does the child appear fearful or protective of the parent?
- Were other people present when the incident occurred?
- Are there other siblings in the home? Do they have "hurts" like these?

Examples of Observable Abuse

- Extensive bruises. Bruises in various stages of healing. Patterns of bruises caused by a particular instrument (belt buckle, wire coat hangers).

- Burn patterns consistent with forced immersion in a hot liquid (distinct boundary line where the burn stops). Burn patterns consistent with a spattering by hot liquid. Patterns caused by a particular kind of implement (electric iron), instrument, or circular cigarette burns.
- Lacerations, welts, abrasions, and/or contusions.
- Injuries inconsistent with information offered.
- Suspicious fractures in children less than three years old; sprains or dislocation.
- Multiple, frequent injuries.
- Skull fractures, subdural hemorrhage or hematoma.
- Human bites.
- Loosened or missing teeth accompanied by lacerated lips.
- Rope marks or burns.
- Poisoning.
- Child is described as "different" in physical and emotional makeup.
- Sexual abuse in any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy, or unnatural or perverted sexual practices.

Examples of Observable Neglect

- Malnourished; ill-clad by community norms; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care.
- Unattended; without adequate supervision; abandonment.
- Ill and lacking essential medical attention.
- Destructive and aggressive behavior exhibited by child.
- Irregular school attendance; truancy.
- Exploited; overworked.
- Emotionally disturbed because of continuous friction in the home; marital discord; mentally ill parents.
- Cruel treatment.
- Depression; suicide gestures; extreme fatigue; anorexia; insomnia; withdrawal; passiveness.
- Child denied experiences of being loved, wanted, secure, or worthy.
- Exposure to unwholesome circumstances.

Common Findings in Abusive Parents

- Parent(s) appears to be misusing drugs or alcohol.
- Contradictory stories regarding child's injury.
- Discourages child forming social contact.
- Evasive answers to questions.
- No voluntary information given regarding any injuries.
- Unrealistic expectations for the child.
- Anger directed at child for being injured.

- Inappropriate response to the child's crying or pain.
- Little touching of the child.
- Little direct eye contact between parent and child.
- Little tenderness shown toward the child.
- Lack of concern regarding child's injury.
- Little or no interest shown for child's treatment.
- Poor relationships with own parents.
- Reared in homes where excessive punishment was the norm.
- Tend to be antagonistic, suspicious, and fearful of others.
- Neglectful of own physical health.
- Personal or marital problems.
- Isolated and transient; seems to have no one to call upon when stresses of parenthood are overwhelming.
- Grew up in unloving atmosphere under harsh discipline, and feel the right to impose same conditions on a child.

Reporting Procedures

Any person who believes that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect must report these suspicions to the Texas Department of Human Resources, and to a law enforcement agency.

An oral report must be made immediately to the nearest office of Child Protective Services, Texas Department of Human Resources, or to the 24-hour Child Abuse Hotline (1-800-252-5400), and to a local law enforcement agency. A written report must be made within five days.

School personnel suspecting child abuse or neglect may use the following steps when reporting such cases:

- The report may first be made to the building principal who may handle any cases in the school.
- The principal may ascertain the facts in the case and may call in one or more of the following: school nurse, teacher, visiting teacher, counselor, or others.
- If the principal suspects child abuse or neglect, the Child Protective Services, Texas Department of Human Resources, and a law enforcement agency should be called immediately to apprise them of the case. An oral report is required by law and may be made also through a Child Abuse Hotline (1-800-252-5400).
- If flagrant abuse is observed, photographs should be made. This, however, shall be the responsibility of the Child Protective Services. Taking photographs is a phase of investigation, and investigation is not the responsibility of the school.
- Nothing in this handbook is intended to prevent the individual nurse, teacher, or other school-related persons from reporting directly to the Child Protective Services or to a local law enforcement agency. The law states that it is a misdemeanor not to report suspected child abuse under penalty of a fine or jail sentence, or both. Being a nurse or a teacher and at school does not relieve anyone of this duty.
- School personnel who may be called as witnesses in court on child abuse cases should be permitted to testify without loss of school salary.

A suggested reporting form is provided in Section E-7.1. School districts may wish to adapt the form to local needs. However, if major changes are made, the school attorney should be consulted.

Report of Child Abuse or Neglect

Section E-7.1

IT'S THE LAW: Any person who believes that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or that a child has died of abuse or neglect, must report his or her suspicions to the Texas Department of Human Resources and to a law enforcement agency.

An oral report must be made immediately to the nearest office of Child Protective Services, Texas Department of Human Resources, or to the 24-hour Child Abuse Hotline (1-800-252-5400), and to a local law enforcement agency. A written report must be made within five days.

IMMUNITY: A person who, without malice, makes a report or suspected child abuse or neglect is immune from civil or criminal liability.

CONFIDENTIALITY: Reports of child abuse or neglect are confidential. Information in the reports, including the name of the person who makes the report, may be used only for purposes consistent with the investigation of abuse or neglect.

FAILURE to report suspected physical or mental abuse or neglect of a child in Texas is a crime punishable by fine, imprisonment, or both.

(The form below is furnished to help Texans comply with the law.)

Detach, seal, and mail

REPORT OF CHILD ABUSE OR NEGLECT

Name of Child	Date of Birth or Age of Child	Today's Date
Child's Home Address (Street, City, State, ZIP)		
NAMES OF PARENTS OR PERSONS RESPONSIBLE FOR CHILD		RELATIONSHIP TO CHILD

Does the child have any brothers or sisters? ☐ Yes ☐ No ☐ Don't Know

When and where can the child be seen? (give dates and places) _____

Type of Child Abuse or Neglect						
☐ Burning	☐ Beating	☐ Fracture	☐ Sexual Abuse	☐ Abandonment	☐ Malnutrition	☐ Internal Injuries
☐ Physical Neglect	☐ Medical Neglect	☐ Lack of Supervision	☐ Other (specify): _____			

Briefly describe the situation and/or condition of the child: _____

Has this report already been called in? ☐ Yes, to local Child Protective Services ☐ Yes, to Child Abuse Hotline ☐ No

If yes, date: _____ To whom? _____

PERSON MAKING THIS REPORT (Anonymous reports are accepted, but DHR staff will be able to do a better investigation if they can contact you.)

Name	Place of Employment	
Work Address (Street, City, State, ZIP)	Work Telephone No.	
OR, I prefer to be contacted at home: ☒	Home Address (Street, City, State, ZIP)	Home Telephone No.

Suicide

Section E-8.0

The incidence of suicide in teens, 15-19 years old, has tripled in the past ten years. The Bureau of Vital Statistics places suicide as the third most frequent cause of death in teenagers in Texas during 1982. The rise in suicides and attempted suicides among youth is attributed to an increase in depressive illness. One suicide attempt is often followed by another, with each succeeding attempt more likely to be successful. Girls account for more suicide attempts, but boys' attempts are more often successful. Most suicides occur at home and result from drug overdose. Analgesics, sedatives, and tranquilizers are commonly used drugs, taken impulsively as a suicide gesture.

The attempted or successful suicide may represent self-destructive impulses, aggression toward parents, or an attempt to control the behavior of other persons. Gestures or attempts may be used to induce guilt and remorse in other people. Quarrels with family or friends, school difficulty, pregnancy, or sexual problems may provide precipitating circumstances. Analysis of the gestures or attempted suicides may identify the particular "appeal for help" or intent, and provide a focus for subsequent help.

Students making suicide attempts are most likely to have: a family in which a relative has committed suicide, only one parent in the home, multiple social and emotional problems, recent evidence of escalation of problems, and evidence of social isolation or recent deterioration of social relationships. These same characteristics frequently occur in young people who are non-suicidal, making it difficult to anticipate suicide or suicidal attempts. Health professionals should consider the possibility of suicide when working with disturbed youths. Though most students attempting suicide do not wish to die and the attempts are frequently unsuccessful, none should be regarded lightly.

School health personnel with knowledge of a youth's suicide gesture or attempt have an obligation to discuss it with the student at once and, with or without the student's consent, to make this information known to the parents immediately.*

*American Academy of Pediatrics, *School Health: A Guide for Health Professionals* (Evanston, Illinois: The Academy, 1981).

Facts and Fables on Suicide

Section E-8.1

- FABLE:** People who talk about suicide, don't commit suicide.
- FACT:** Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.
- FABLE:** Suicide happens without warning.
- FACT:** Studies reveal the suicidal person gives many clues and warnings regarding suicidal intentions.
- FABLE:** Suicidal people are fully intent on dying.
- FACT:** Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he or she is feeling.
- FABLE:** Once a person is suicidal, he is suicidal forever.
- FACT:** Individuals who wish to kill themselves are "suicidal" only for a limited period of time.
- FABLE:** Improvement following a suicidal crisis means that the suicidal risk is over.
- FACT:** Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.
- FABLE:** Suicide strikes more often among the rich—or conversely, it occurs almost exclusively among the poor.
- FACT:** Suicide is neither a rich man's disease nor the poor man's curse. Suicide is very "democratic," and it is represented proportionately among all levels of society.

- FABLE:** All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
- FACT:** Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he or she is not necessarily mentally ill.

N.L. Farberow and E.S. Schneidman, *Some Facts About Suicide* (Washington, DC: Public Health Service, Publication No. 852, U.S. Government Printing Office, 1961).

Warning Signs of Suicide

Section E-8.2

- ☐ Verbalized suicide threats.
- ☐ Statements revealing a desire to die.
- ☐ Plans made regarding how suicide will be carried out.
- ☐ Previous suicide attempts.
- ☐ Acting out daredevil acts; truancy, or delinquent behavior.
- ☐ Hyperactive or manic behavior.
- ☐ Overeating or oversleeping.
- ☐ Sudden changes in behavior (withdrawal, apathy, moodiness).
- ☐ Observable changes in peer relationships (social withdrawal, frequent absences, sudden difficulty with academic material).
- ☐ Depression (crying, sleeplessness, loss of appetite, hopelessness).
- ☐ Impulsive reactions connected with anger or acute humiliation.
- ☐ Frequent clinic visits with somatic complaints.
- ☐ Final arrangements (such as giving away personal possessions).

What To Do:

- ☐ Discuss suicide openly and frankly.
- ☐ Show empathy, interest, and support; establish rapport.
- ☐ Bring parents into situation and advise prompt consultation with a psychiatrist or community resource.
- ☐ Get professional help; establish community liaison with psychiatrist or other mental health professional.

Section F

Student Services

Section F	Student Services
	1.0 Health Counseling
	2.0 Health Instruction
	3.0 Health Screening
	3.1 Physical Assessment
	3.2 Physical Examination
	3.21 Physical Examination Form
	4.0 Growth and Development Screening
	4.1 Height Chart—Girls
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	6.1 Basic Visual Acuity Test and Criteria
	6.2 Sample: Vision Screening and/or Eye Examination
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	7.0 Audiometric Screening
	7.1 Relationship of Degree of Impairment to Educational Needs
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	7.21 Sample: User of Audiometer Registration Form
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	8.0 Scoliosis Screening
	8.1 Drawings for Scoliosis Screening
	8.2 Scoliosis Screening Worksheet
	9.0 Hypertension Screening
	9.1 Percentiles of Blood Pressure Measurement

Health Counseling

Section F-1.0

Definition

Health counseling may be defined as that interaction among the health professional, client, and/or others for more effective management of student or staff health problems.

General Goals

- To assist in maximizing learning by meeting health needs of students.
- To involve students and other health care providers in assuming responsibility for health care, health maintenance, and reinforcing appropriate health habits.
- To provide options or assistance for informed client choices and referral.

Counseling—With Students

Goal: To Involve Students in Own Health Care

The goal is for students to develop an awareness of good health behaviors and to use these behaviors in becoming responsible for own health care.

The school nurse consults and counsels with students:

- To provide information needed to prevent health problems. This counseling and/or consultation may be done with individuals or in small groups and will cover topics such as eye and ear protection, dental flossing, etc.
- To provide an interpretation of health data to those students with existing health problems. This interpretation will include recommendations on ways to use the information in preventing further health damage, e.g., spinal curvature-exercise, obesity-diet.
- To provide the immediate assistance and information needed in the management of health problems which can be remediated, e.g., preventing the spread of infectious or contagious diseases.
- To provide the information and support needed in learning to accept limitations for which there is no remediation at the present time; and build constructively toward achieving the fullest positive potential adjustment, e.g., arthritis, amputation, Spina Bifida.
- To provide information about community health and social resources which are available to furnish needed services beyond the scope of the school, e.g., hospital emergency room, public health department, community service clubs, mental health and retardation resources, and community substance abuse programs.

Goal: To Involve Parents in the Promotion of Good Health Behavior

The goal is for parents to become aware of good health practices and behaviors which will facilitate the student's learning.

The school nurse will consult and/or counsel with the family through individual or study group sessions and:

- Provide current information on health promotion and prevention practices, e.g., growth and developmental stages, healthy snack foods, personal hygiene needs of different age groups.

- Determine student's health problem(s) and assist parents in identifying health resources through activities such as school health screening and referral, development of a list of private physicians, optometrists, or community resources.
- Explain and provide specific information about health handicaps and what will be the most beneficial and least restrictive environment for both the child and other family members, e.g., blood dyscrasias.
- Explain and reenforce the medical information received from outside sources as a part of screening follow-up.

Counseling—With Staff

Goal: To Involve the School Staff in Using Health Information To Facilitate Learning for Students With Health Problems

The goal is for the school staff to become better informed about individual student health problems and make adequate environmental adjustments.

The school nurse will consult with those school staff members working with individual students who have health problems needing specific classroom accommodations:

- To provide the most effective learning environment, e.g., seating adjustment for visual/hearing difficulties or wheelchairs, restroom assistance or flexibility.
- To assist the staff in understanding and accepting limitations of handicapped students when planning curricular activities, e.g., leaf collecting-asthmatic child, bird watching-visually handicapped, manual dexterity and physical coordination-child with muscle atrophy.

Goal: To Involve Staff in Modeling Good Personal Health Practices

The goal is for the school staff to become aware of and use good personal health practices, thus serving as a model for students.

The school nurse will consult with school staff individually or in small groups by:

- Providing current information regarding good health practices which pertain to the staff's occupation and work setting, e.g., eye strain, stress, food habits.
- Identifying good health practices which may be reenforced through staff modeling, e.g., posture and exercise.
- Preventing unnecessary health problems and promoting good health practices, e.g., use of health week activities, bulletin boards, role playing, media.

Goal: To Involve School Staff in the Use of Community Health Resources

The goal is for the school staff to be aware of community health resources, of the services provided by each resource, and how to initiate a referral to the community resource which provides assistance for a student's health needs.

The school nurse will consult with and provide information concerning community services available to staff members by:

- Preparing and disseminating a list containing community health resources available to assist with the health needs of students, families, and staff, e.g., American Red Cross, American Cancer Society, American Heart Association (see Section AA of this handbook).

Health Instruction

Section F-2.0

Health instruction is an important component of every student-nurse contact. Health instruction supports public education's goal of preparing a citizen with positive health knowledge which is used to make responsible decisions concerning the care of self, family, and community.

The Professional Nurse Has Three Key Roles in Health Instruction

- To act as a role model of healthful living for the school community.
- To support classroom instruction in select content areas.
- To consult and serve as a resource to students, faculty, and community.

Roles, Competencies, and Activities

Role

The school nurse must act as a role model for healthful living for students, staff, and community.

Competencies

- The nurse must be able to formulate models for healthy behavior derived from scientifically-based literature.
- The nurse must be able to describe, discuss, and explain individual behavior, anatomy and physiology, disease process, and developmental stages when considering healthy behavior changes or attitudes.
- The nurse must be able to demonstrate a commitment to health practices and prevention of poor health by education and example.

Examples of Activities

- Demonstrate infection control measures.
- Promote health weeks.
- Provide safety programs.
- Practice good health behaviors.
- Display health information on bulletin boards.
- Act as a health advocate.

Role

The school nurse must be able to support classroom instruction in select content areas pertaining to health-related material.

Competencies

- The nurse must be able to demonstrate a proficiency to prepare and present health-related material in the classroom to supplement the classroom teacher's curriculum.
- The nurse must be able to demonstrate a proficiency in classroom management.
- The nurse must be able to provide knowledge and understanding of the district's health curriculum, including goals and objectives for student learning.
- The nurse must be able to utilize varied teaching strategies to enhance the learning process.
- The nurse must be able to provide information and promote understanding of developmental stages as they pertain to student health and health instruction.
- The nurse must be able to support classroom curricular by remaining current on health-related research and scientifically-based data.

Examples of Activities

- Teach selected topics, such as cardiopulmonary resuscitation (CPR), first aid, nutrition, body systems, germ theory, communicable disease, health screening procedures, or personal hygiene.
- Participate in continuing education on inservice programs pertaining to teaching techniques, research, or new theories.
- Assist in curriculum development and textbook selection.

Role

The school nurse must act as a health consultant and resource to students, staff, and community.

Competencies

- The nurse must be able to design, plan, and deliver health education programs for students, staff, and community.
- The nurse must be able to formulate and maintain effective working relationships with members of the populations served.
- The nurse must be able to develop a list of available community health education resources.
- The nurse must be able to provide materials and information to supplement the classroom teacher's curriculum.

Examples of Activities

- Provide growth and development films, breast self-exam speakers and film, testicular cancer speakers and film, or courses on babysitting.
- Inform teachers of health-related topics which have been prepared, e.g., CPR, baby care, hypertension.
- Interpret medical problems and care plans for specific health problems, e.g., hemophilia, narcolepsy, sickle-cell anemia.
- Instruct staff on recognition of communicable diseases, e.g., Pediculosis, scabies, chicken pox.

- Describe modes of infection transmission, e.g., hepatitis.
- Develop a list of community resources (see Section AA).
- Accumulate health education information.
- Instruct students in meeting own minor health care needs and personal health assessment, e.g., wound cleansing, application of ice/heat; recording temperature, pulse, respiration, height/weight.

Health Screening

Section F-3.0

The objective of screening students is to detect health problems. A good screening program is rapid and is accepted by the students and staff.

Nurse Responsibilities

- Maintain appropriate equipment for screening.
- Pre-plan with involved teachers prior to the day of screening.
- Obtain or update health history.
- Utilize health screening as a vehicle for one-to-one health counseling and health education.
- Adapt screening tools to appropriate mental age of students.
- Record all findings on health record.
- Record results of follow-up on screening activities (re-test, medical referral, etc.). Screening is of no value without adequate follow-up resulting in appropriate treatment.

Important Things to Remember

- Schedule appropriate time via telephone for parent contact, home visit, parent school visit regarding referrals on all significant health problems.
- Schedule a teacher-nurse conference following student screening to discuss health problems and their educational implications.
- Notify appropriate building staff of students with significant medical problems and health program adjustment.

Physical Assessment

Section F.-3.1

A health history should be obtained on all kindergarten students (first grade if this is the entering grade) and on all new students. A more in-depth history is appropriate on students who are candidates for special education or who have continuing health problems.

The following divisions are commonly used in obtaining a patient health history: current health problems, significant past history, review of systems, and family and social history. Although much useful information may be obtained from students, it is usually less complete and accurate than that provided by parents. Always note the source of the information gained and its probable reliability.

Current Health Problems

- Child's general health.
- Absent more than five days of previous or current school year due to illness or accident; type of illness or accident.
- Last seen by a doctor or health clinic; reason.
- Medication taken on regular basis; what; during school hours.
- Known allergies (asthma, hay fever, reactions to drugs or foods).
- Immunizations current.

Significant Past History

- Problems with pregnancy (bleeding or cramping, fever, exposure to infections such as measles, excessive swelling or weight gain); previous number of pregnancies; previous miscarriages; medication taken during pregnancy; use of alcohol or tobacco during pregnancy.
- Labor or delivery difficult or complicated (labor longer than 10 hours, C-section, excessive bleeding, breech presentation, forceps).
- Child breathed immediately after birth and had a good color.
- Child given oxygen or placed in an incubator after birth.
- Birth weight (note if under five pounds).
- Problems in nursery before discharge from hospital.
- Development (indicate month skill attained): walked unassisted; put words together (hi daddy/go bye-bye) with meaning.

Review of Systems

- Vision or hearing problem.
- Convulsive disorder (seizure or epileptic "fit").
- Frequent staring spells or daydreaming.
- Tires easily.
- Recent weight loss (over five pounds) or gain (over ten pounds) in past year.
- Bowel and bladder habits normal.
- Balance and coordination as good as other children of the same age.
- Indication by teacher that the child has difficulty concentrating or paying attention; ability to sit still long enough to watch a 30 minute television program.

Family and Social History

- Number of children in the home; both parents living in the home.
- Upsetting circumstances in the home which might affect the child's school performance.

- Family members who now have or previously had any of the following:

blindness	deaths or degenerative diseases in children or young adults
cerebral palsy	diabetes
learning difficulty (especially reading)	blood dyscrasias
mental retardation	congenital abnormalities
deafness	cardiovascular diseases
seizures/convulsions	other inherited problems
- Other information parent or student may wish to add.

Physical Examination

Section F-3.2

The school nurse must receive specialized training in physical assessment skills before attempting to use special appraisal techniques. Nurses are encouraged to continually practice assessment skills on "normal, healthy" children in order to recognize the comparison of abnormal findings. The physical exam report should include results of previous screenings and available lab reports (see Section F-3.21).

A systematic approach is necessary when doing a physical exam. The preferred method is to start at either the head or the feet, and methodically examine each body part. The four basic physical assessment techniques are: *observation*, *palpation*, *percussion*, and *auscultation*.

Observation

Inspection with the naked eye will give most of the information needed, but tools such as the otoscope and ophthalmoscope will also be helpful.

- Observe general appearance:
 - State of health, integument, growth development, posture, and motor activity.
 - Grooming, personal hygiene, odors, facial expression, awareness, manner, and speech.
- Body symmetry: size, shape, and placement of body parts, scars, birthmarks, masses, or any weaknesses.

Palpation

Includes touching, feeling, noting skin temperature, and vibrations. Use pads of fingers for fine tactile details, back of fingers are most sensitive to skin temperature, and flat of palm and fingers perceive vibrations such as cardiac thrills most accurately.

- Head/neck: Palpate skull for bony configuration, lymph nodes for enlargement, carotid pulses for intensity and symmetry, the position of trachea and size of thyroid gland.
- Face, eyes, ears: Palpate mastoid processes, auricle of ear, sinuses for tenderness.
- Thorax-lungs:
 - Axillary lymph nodes, nipples, chest wall for tenderness.
 - Lungs for vocal tactile fremitus.
- Heart palpate precardium for Point of Maximal Impulse (PMI)—heaves, lifts/thrills.

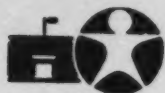
- Abdomen:
 - Light palpation over all four quadrants for tenderness.
 - Deep palpation for liver, spleen, kidneys.
- Muscles, skeleton: Palpate posterior tibial and dorsal pedis pulses, radial pulses.

Percussion

Helps to determine the density of the underlying parts and whether they are air-filled, fluid-filled, or solid. Percuss over lung fields, abdominal quadrants, borders/span of liver, spleen, and masses.

Auscultation

- Stethoscope: Amplifies and focuses sound over area. Ear pieces cut out other sounds and should fit snugly. Stethoscope should have both bell and diaphragm.
- Auscultate: For breath, heart and bowel sounds, bruits of skull or thyroid, murmur in neck or abdomen, and for friction of ribs.



Section F-3.21

NAME _____

[illegible]

Growth and Development Screening

Section F-4.0

All children should make gains in height and weight more or less regularly from birth to maturity. Seasonal growth and individual differences in body structure as well as hereditary factors must be kept in mind since there is a variation in children of the same age.

Growth and development are directly related to inherited characteristics and environmental influences throughout the life cycle. Although growth and development generally follow maturational sequences, culture and the quality of the environment exert significant influences on a person's growth and development.

The quality of the environment may directly and/or indirectly influence an individual's growth and development. Physiological needs such as nutrition, sleep and activity; safety needs including protection from elements in the environment such as noise, air and water pollution, crowding and poor sanitation; and the need for love, all influence the individual's growth and development.

Culture may influence growth and development through nutrition, physical/social activities, and stress-handling patterns. Height and weight attainment, as well as disposition to a particular state of health, have their roots in the early developmental period but continue to change throughout the years in school.

Because each individual has a unique interaction with members of the culture and selected aspects of the environment, growth and development patterns may or may not fit into the table or graph of "norms" for each age. Each individual's growth and development should be viewed and assessed according to unique potential relative to cultural and environmental constraints.

Growth and development assessment should be conducted regularly. Notation of head circumference should be made at the initial assessment for baseline establishment. If head development appears unusual, sequential notation should be made. The significance of changing growth and developmental patterns should be discussed with parents in order to promote awareness and responsibility for achieving and/or maintaining optimal health.

Purpose

- To identify the child who is not growing and developing normally.
- To stimulate interest in self-responsibility for growth and development.
- To show relationship between good health practices and growth.
- To create an awareness among school personnel and parents of the relationship of good nutrition to growth.

Procedures and Techniques

- Be sure that scales are in accurate balance.
- Have the student remove shoes, coats, extra sweater, and any heavy objects in pockets.
- Have the student who is not wearing socks place a paper towel on the scale platform before weighing and remove it afterwards. Use measuring board for measuring height.
- Record weight to the nearest pound/half-pound; height to the nearest inch/quarter-inch.
- Students with possible abnormal growth patterns should have height, weight, and head circumference comparisons to age group norms (see tables, Sections F-4.1, 4.2, 4.3, 4.4, 4.5, and 4.6). Those whose height or weight is less than the three percentile or greater than the 97 percentile should be referred to the family physician or a public health clinic.
- A flexible narrow steel tape is recommended for measuring the head circumference. Apply the tape firmly around the child's head above the supraorbital ridges or the most prominent part of the frontal bulge, anteriorly, and over that part of the occiput which gives maximum frontal-occipital circumference.

Follow-Up Procedures

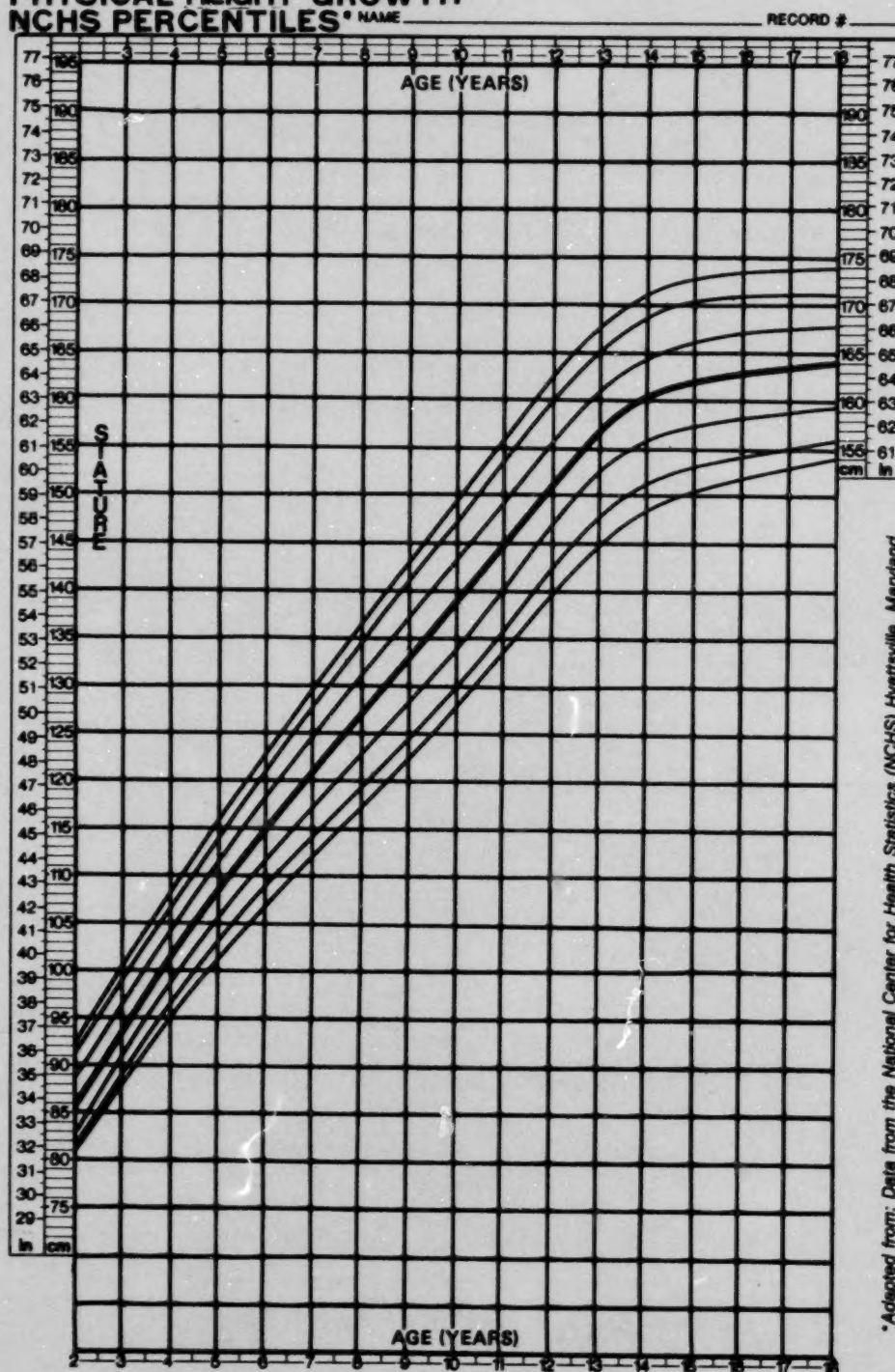
- Confer with teacher and parents; refer children who are gaining or losing weight excessively to family doctor or public clinic.
- Re-weigh students who need follow-up at appropriate intervals.

Suggestions

- *Health Instruction:* Weighing and measuring should be accompanied by instruction that capitalizes on normal growth and development.
- *Nutrition Education:* Home economics or health classes in high school and health classes in elementary school may relate nutrition to growth and development.
- *Writing:* The teacher may wish to have the child take home a record of height and weight.
- *Arithmetic:* The measurements of food, especially those concerned with ounce, pound, and half-pound; the average weight of boys and girls; graphs and charts may be used.
- *Spelling:* Learning to spell words concerned with height, weight, and measurement.

Height Chart—Girls

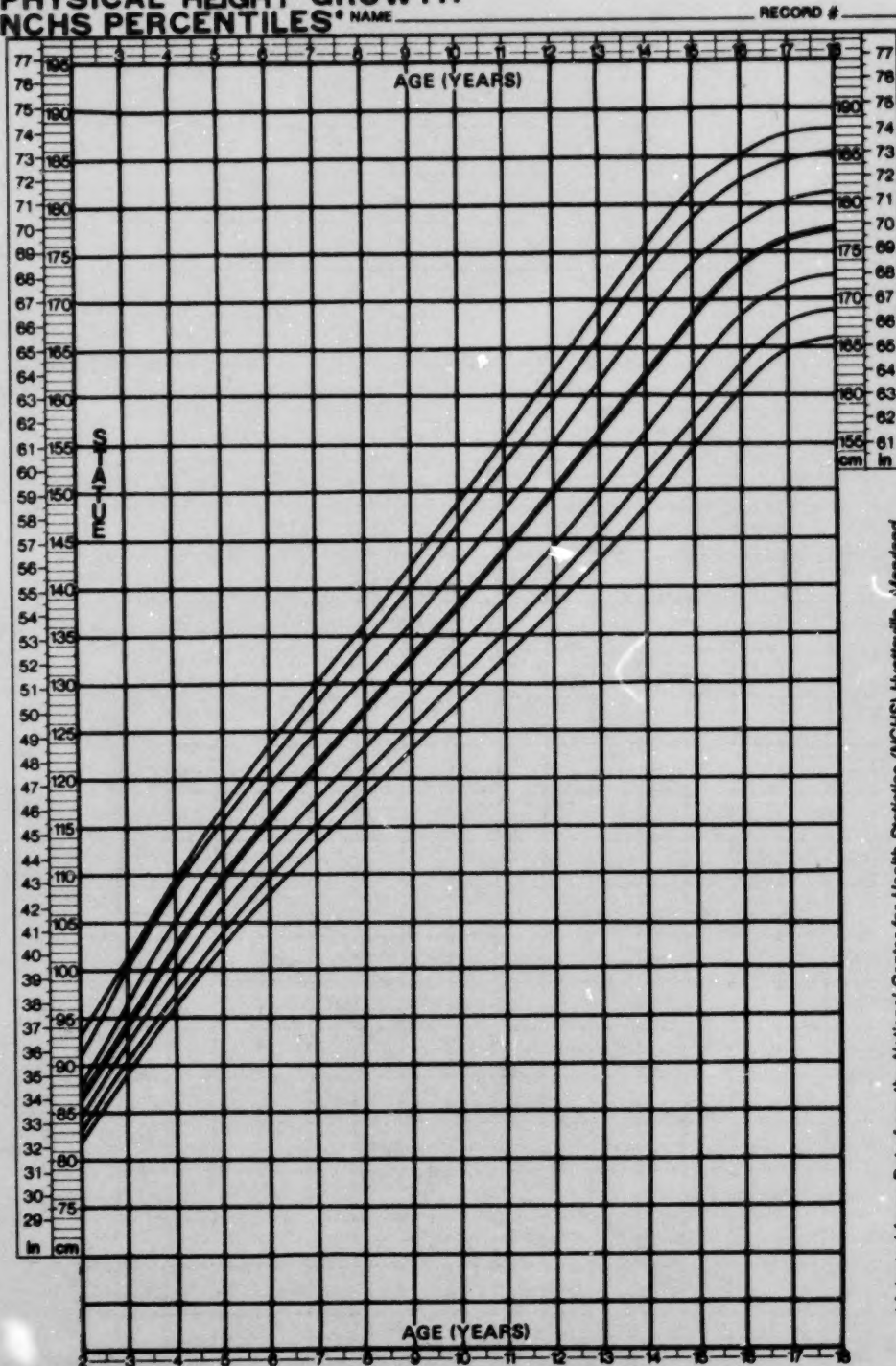
Section F-4.1

**GIRLS: 2 TO 18 YEARS
PHYSICAL HEIGHT GROWTH
NCHS PERCENTILES**

*Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

Height Chart—Boys

Section F-4.2

**BOYS: 2 TO 18 YEARS
PHYSICAL HEIGHT GROWTH
NCHS PERCENTILES***

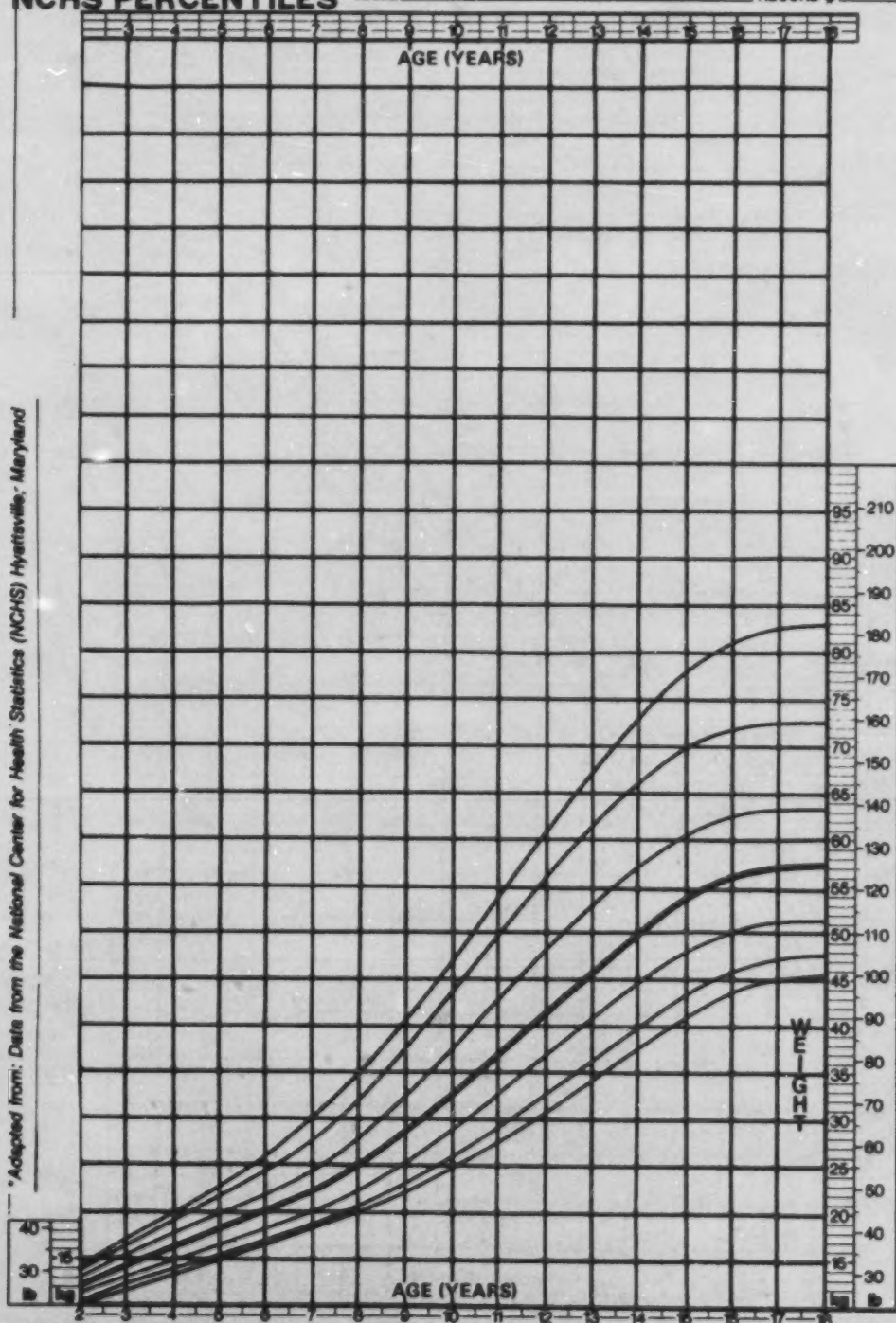
*Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

Weight Chart—Girls

Section F-4.3

**GIRLS: 2 TO 18 YEARS
PHYSICAL WEIGHT GROWTH
NCHS PERCENTILES** * NAME _____

RECORD # _____



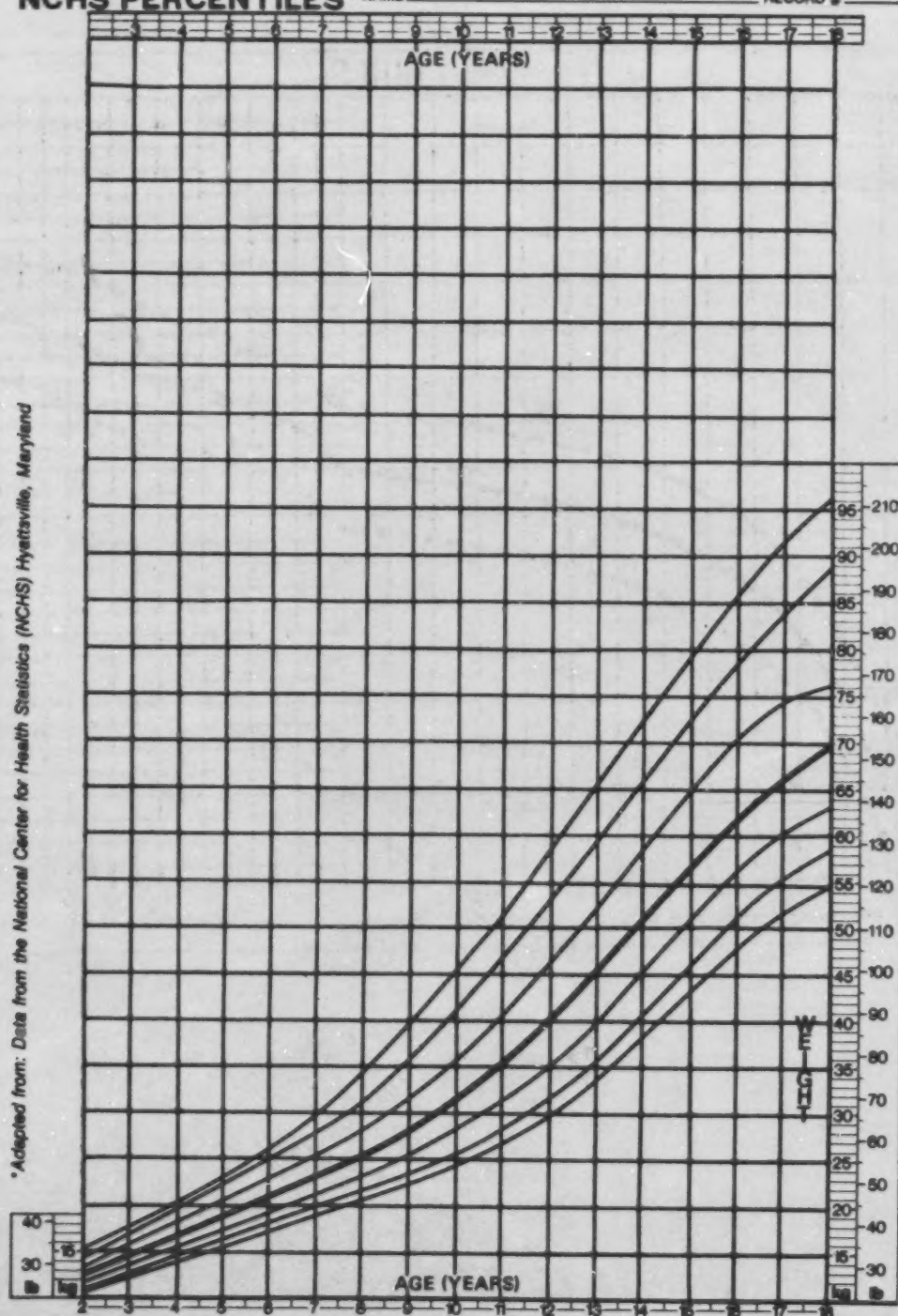
Weight Chart—Boys

Section F-4.4

BOYS: 2 TO 18 YEARS
PHYSICAL WEIGHT GROWTH
NCHS PERCENTILES

NAME _____

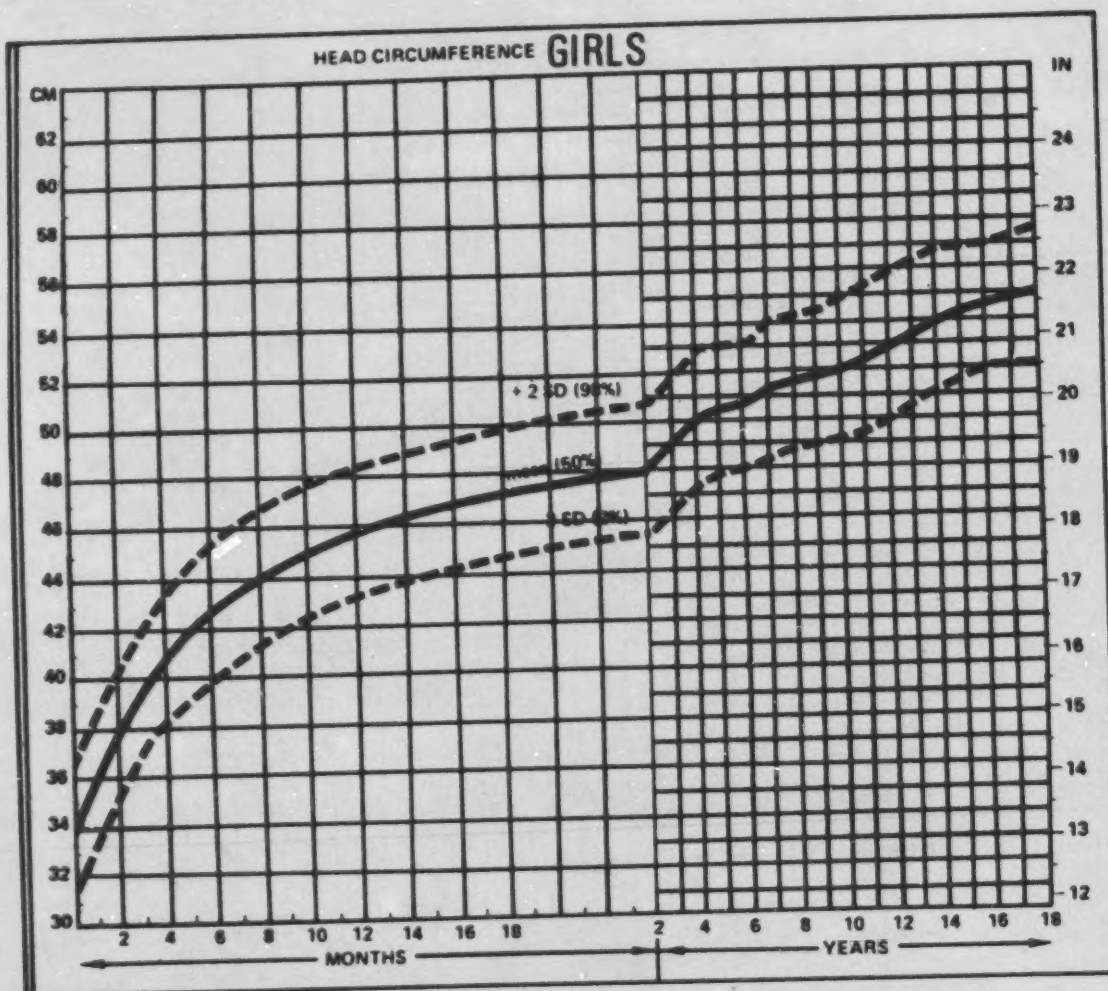
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*Adapted from: Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

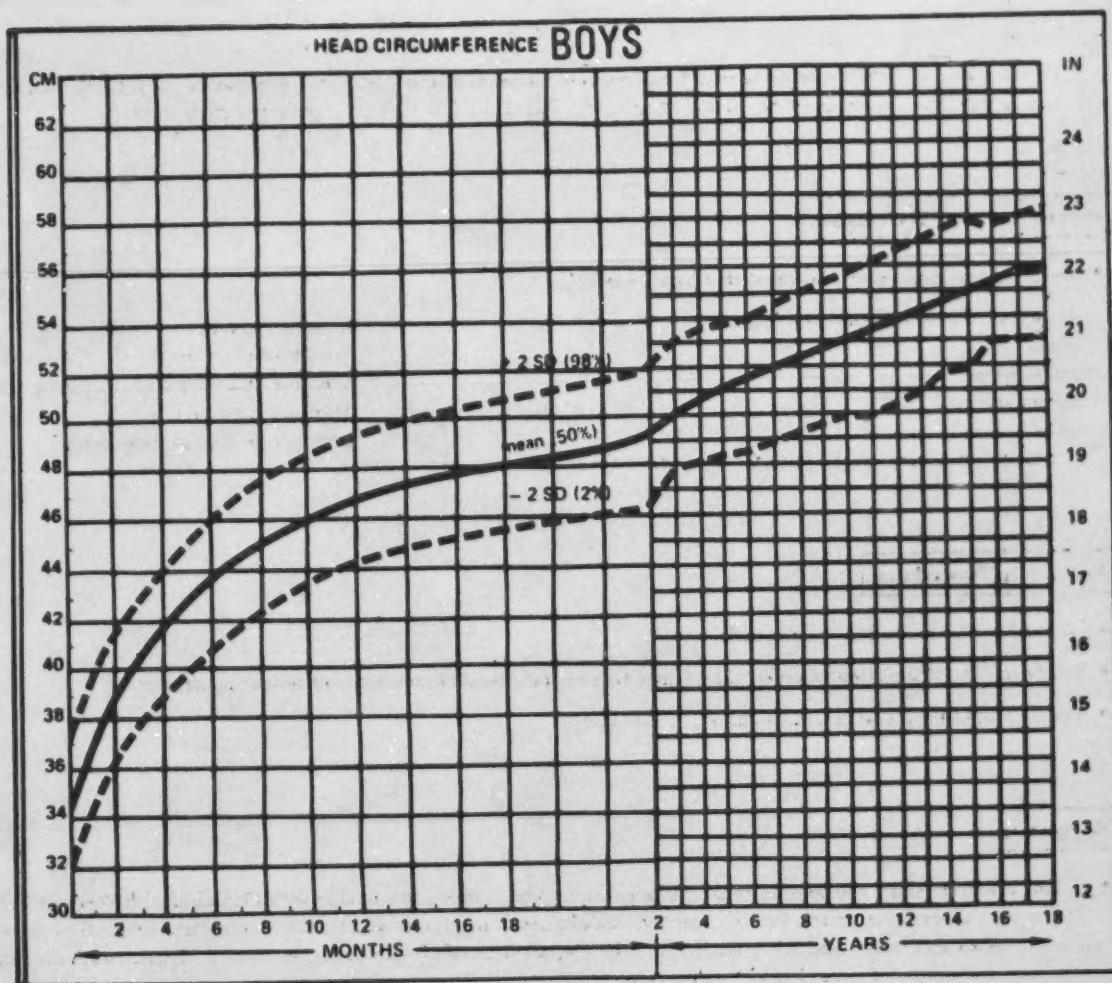
Head Circumference—Girls

Section F-4.5



Head Circumference—Boys

Section F-4.6



Dental Screening

Section F-5.0

Since dental disease affects more students than any other single health problem, it is important that a school health service include dental screening and education. However, students should also be checked by a private dentist at least every six months.

Purpose

The purpose of dental screening is to help educate students about good oral hygiene, to help preserve permanent teeth, to detect abnormalities or problems requiring referral, and to promote general physical health.

Procedures and Techniques

- Use a tongue depressor and adequate light. Look for:
 - abnormalities of mucous membrane
 - caries
 - oral hygiene
 - malocclusions
 - broken teeth
 - retaining temporary teeth (past the age when generally lost)
 - missing permanent teeth
 - supernumerary teeth
 - need for spacer bridge or partial denture
 - dead anterior teeth
 - presence of dental prosthesis

Follow-Up Procedures

- Counsel with the student as needed.
- Notify parent of any dental defect using procedures indicated in referral and follow-up section.
- Assist in obtaining correction of defect, if necessary.

Suggestions

- *Health:* When possible, the dental health education should be planned to coincide with Dental Health Week in February. The nurse, a resource person for the teacher, should assist in planning classroom activities, using filmstrips, large tooth brushes and teeth, and other materials. The Department of Health or Texas Dental Hygienists Association are excellent resources for dental health education.
- *Nutrition:* Health classes in elementary schools may relate nutrition to health, teeth, and gums.
- *Writing:* Teachers may wish to have children keep records of temporary tooth loss related to age or write stories during Dental Health Week.
- *Arithmetic:* Students may be taught the number of permanent teeth in the upper and lower jaws and the approximate age of eruption.
- *Spelling:* Words related to oral hygiene and permanent teeth may be included in spelling lists.

Eruption Table of Teeth

Section F-5.1

- It is as important for the primary teeth to receive proper care as it is to provide proper care for the permanent teeth.
- Teeth begin to develop before the child is born.
- There are twenty of these teeth:
 - 10 in the upper jaw.
 - 10 in the lower jaw.
- Teeth erupt into the child's mouth between the ages of six months and thirty months.

A Full Set of Primary Teeth

With approximate ages at which eruption occurs.

Central Incisor, 7 1/2 mos.

Lateral Incisor, 9 mos.

Cuspid, 18 mos.

First Molar, 14 mos.

Second Molar, 24 mos.



Upper Jaw
Back of Mouth

Second Molar, 20 mos.

First Molar, 12 mos.

Cuspid, 16 mos.

Lateral Incisor, 7 mos.

Central Incisor, 6 mos.



Lower Jaw

- If at all possible, each tooth should be retained in the mouth until the permanent tooth is ready to erupt.
- Teeth should be brushed or cleansed immediately after eating. As soon as possible the child should be taught how to brush teeth but, until such time, it should be done by an adult.
- It is necessary for a child's dental health to come under professional supervision of the dentist as soon as possible. If primary teeth are lost prematurely or retained past the normal time any or all of the following conditions may result:
 - Crooked permanent teeth.
 - Irregular and unattractive features when older.
 - Increased cost of dental service.
- If teeth are left unattended, the result may be:
 - Pain for the child (toothache).
 - Sickness for the child (through infections in the mouth).

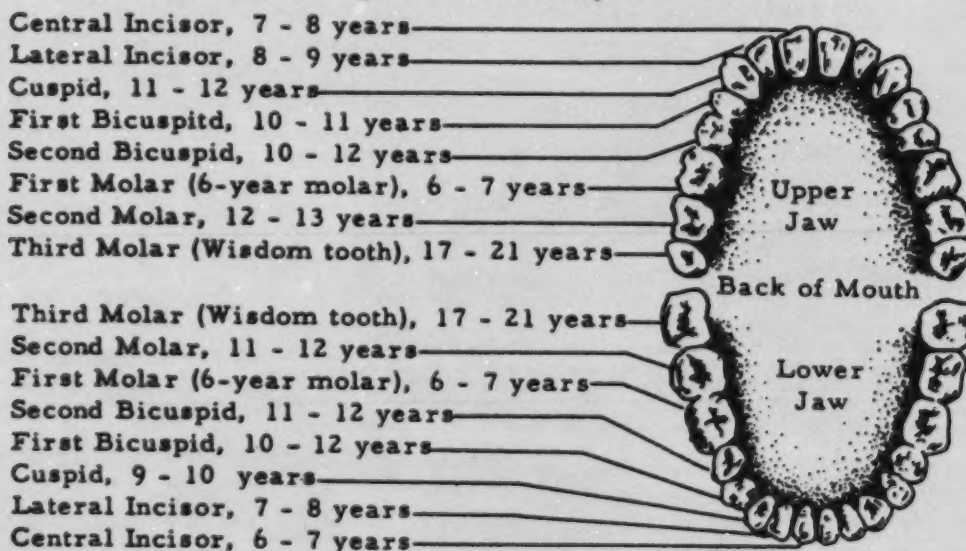
First Permanent Molars

Section F-5.2

- The "six year molars" are the first of the permanent teeth to erupt in the child's mouth.
- There are four of these teeth, one each on the right and left sides of the upper and lower jaws.
- These erupt into the mouth when the child is approximately six years of age.
- Molars appear behind primary teeth, but do not replace them.
- To determine if the child has any or all of these teeth:
 - Start at the center of mid-line of the child's mouth in either jaw.
 - Count, either to right or left of the mid-line, each tooth or space in sequence.
 - If the first permanent molar is present, it will be number six from the mid-line.
- Molars are the "keystones" of the dental arches.
 - Molars help other teeth attain proper alignment.
 - Molars are the sturdiest and largest of any teeth the child will have, so may be used as a guide for other teeth and also as an anchor by the dentist if a child's teeth need to be straightened.
- Losing one or more of these teeth may cause crooked teeth, a deformed mouth, loss of other teeth, infection and/or pain, and unnecessary expense.

A Full Set of Permanent Teeth

With approximate ages at which eruption occurs.



Vision Screening

Section F-6.0

Children entering school for the first time in Texas must have a vision screening, according to the Children's Vision Screening Act of 1979 passed by the Sixty-sixth Texas Legislature. The initial target group includes young children entering kindergarten or first grade and students transferring into Texas schools from other states. The statute requires that all children enrolling in any public, private, parochial, or denominational school for the first time must have an eye examination by a licensed eye specialist or an approved vision screening test. The Basic Visual Acuity Test and Referral Criteria, recommended by the Advisory Committee on Children's Vision and approved by the Texas Board of Health was implemented statewide on September 1, 1980 (see Section F-6.1).

Purpose

The purpose of a vision acuity screening program is to: identify through mass screening any student with vision difficulty, to test further and evaluate those students who failed the initial screening; and to refer for additional examination and possible treatment, if indicated. It is recognized that much learning is acquired through the sense of sight, and any undetected and uncorrected visual defect may affect a student's entire adjustment in school.

Snellen Eye Chart Procedures and Techniques

Screening should be done in a quiet area free from disturbances. When Snellen charts are attached to a wall, the surrounding area should be uncluttered. Use "butcher paper" or other brown paper to cover patterned walls if necessary.

Lighting at the chart should be normal and free of shadows or glare. Illumination on the chart should measure between 10 and 30 footcandles with ambient room lighting no less than one-fifth the amount on the chart. In darker locations or on cloudy days, supplemental lighting with one or two gooseneck lamps may be necessary. (Self-illuminated charts are designed to provide accurate light values.)

The line for referral (20/40 or 20/30) should be on an eye level with the child seated or standing.

A 20-foot distance from the child to the eye chart is preferred. Space limitations or poor testability of the child may dictate the choice of models scaled for use at 10 feet. Charts designed for use at 20 feet should never be used at 10 feet and vice versa.

Linear test procedures are preferred (exposing one line of letters or symbols at a time). Isolated test procedures (a single letter or symbol) are approved according to the sequence shown on the Basic Visual Acuity Tests and Referral Criteria form.

Approved Charts for Basic Visual Acuity Testing

- Snellen Letter Chart (20-foot and 10-foot models).
- Snellen "Tumbling E" Chart (20-foot and 10-foot models).
- HOTV Matching Symbol Test (the 10-foot model only).

All new students must be screened within 90 days for first entry into the school system.

Ideally, all students would be screened for vision and hearing annually. Vision should be tested through grade 10 and may be alternated yearly with hearing screening. In addition, screening should include: students in special education classes; those referred by parent, counselor, or teacher; and those with known vision problems, including those previously referred for follow-up and who did not receive care. Local school district policy should determine grades designated for vision screening. Reporting form samples are provided in Sections F-6.2 and 6.3.

Follow-Up Procedures

The nurse will:

- Notify parents, and refer for evaluation and follow-up students whose visual acuity is below standards.
- Counsel with the parent and assist with or arrange for the correction or treatment of any defect.
- Refer student for placement in special education classes for visually handicapped, if eligible.
- Notify teachers and suggest students be given preferential seating in the classroom, where appropriate.

Suggestions

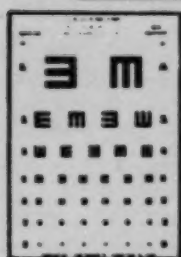
- *Health Education:* The importance of eye care through rest, lighting, and eye protection should be stressed.
- *Nutrition:* Teaching good nutrition for body growth and maintenance for all body systems is an integral part of student education.
- *Arithmetic:* Teach students the distances used for vision screening and the significance of the numerical findings on a Snellen chart.
- *Spelling:* Older students may be taught the definition and spelling of words such as: iris, pupil, conjunctiva, sclera, cornea, and lens.

Basic Visual Acuity Test and Criteria

Section F-6.1

TEXAS DEPARTMENT OF HEALTH
BASIC VISUAL ACUITY TESTS AND REFERRAL CRITERIA

IMPORTANT INFORMATION: The preferred distance visual acuity test is given with a Snellen Chart at 20 feet, using the linear test method. Below are criteria for various age groups as approved by the Advisory Committee on Children's Vision. When a child cannot be tested by the preferred method, test according to the sequence shown below, for the appropriate age, before considering the child not testable. In limited space, a 10-foot chart may be used; however, care should be taken that screeners never use a 20-foot chart at a distance of 10 feet. When using HOTV matching symbols, only the 10-foot HOTV is approved. If stereoscopic instruments are used to test visual acuity, use the same referral standards as shown below; however, children failing such testing should be re-screened with an approved chart, at distance, before being referred. REGARDLESS OF THE RESULTS OF ANY SCREENING TEST, OBSERVATION OF OBVIOUS SIGNS OF EYE PROBLEMS WOULD BE THE BASIS FOR REFERRAL FOR A PROFESSIONAL EYE EXAMINATION.

Tests for Ages 3 & 4"Tumbling E"

linear @ 20'
isolated @ 20'
linear @ 10'
isolated @ 10'

H:O:T:V TestReferral Standards

All children should be screened thru the 20/20 line. Must read a majority (one more than half) of the 20/40 line, or 4 out of 6 HOTV symbols (of 20/40 size). Children with a two-line difference between the two eyes should be referred.

Tests for Age 5

(SAME AS: Ages
3 & 4.)

Referral Standards

Must read majority of 20/30 line, or 4 out of 6 HOTV symbols of that size.

Tests for Ages 6 & UpLetter Chart

linear @ 20'

"Tumbling E"

linear @ 20'
isolated @ 20'
linear @ 10'
isolated @ 10'

H:O:T:V Test

@ 10'

Referral Standards

Must read majority of 20/30 line, or 4 out of 6 HOTV symbols of that size.

REFER AFTER SECOND SCREENING

M-61 1980

Sample: Vision Screening and/or Eye Examination

Section F-6.2

**TEXAS DEPARTMENT OF HEALTH
VISION SCREENING and/or EYE EXAMINATION**

ATTENTION PARENT: Please present this certificate when enrolling your child in school for the first time. Article 4419f, Texas Revised Civil Statutes, requires that every child have an eye examination or approved vision screening test prior to, or within 90 days after, entry into a Texas school.

SCHOOL _____ CITY _____ COUNTY _____
 Child's Name _____ Birth Date _____ Age _____ Sex _____
 Parent's Name _____ Telephone Number _____
 Address _____ Zip Code _____

VISION SCREENER REPORT

Visual acuity screening is only a check of the sharpness of a child's vision and should not be interpreted as a substitute for a complete vision examination. A child who fails this screening should be referred to an eye specialist for a complete visual examination.

VISUAL ACUITY
First test

Right Eye 20/
 Left Eye 20/

Screened with glasses? Yes ☐
 No ☐

☐ Snellen Chart
☐ Other: _____
 (instrument)

SCREENING RESULTS

PASSED ☐
 FAILED ☐

Second test

Right Eye 20/
 Left Eye 20/

☐ Snellen Chart
☐ Other: _____

PASSED ☐
 FAILED - REFERRED ☐

Observable Signs _____

Other Tests(s) _____

Reason for referral to Eye Specialist _____

DATE _____ VISION SCREENER _____ ORGANIZATION RESPONSIBLE FOR SCREENING _____

**EYE SPECIALIST REPORT
(Ophthalmologist or Optometrist)**

VISUAL ACUITY

Without correction

With correction

RIGHT EYE

20/

20/

LEFT EYE

20/

20/

Problem(s) noted: _____

PLEASE CHECK IF APPROPRIATE:

Recommendations:

- ☐ Medical evaluation
☐ Glasses
☐ Contact Lenses
☐ Other: _____

Corrective Lens prescribed

- Constant Wear
 Near Vision only
 Far Vision only
 May be removed for physical education

Re-examination advised

- ☐ Six months
☐ Twelve months
☐ Other: _____

Please print or stamp

Doctors Name: _____

Address: _____

City: _____

Present Date _____

Date of last examination _____

Please retain this certificate with other health records of the child.

DOCTOR'S SIGNATURE _____

1980

White — School (Child's Health Record). Canary — Health Department. Pink — Screening Organization.

M-60

Sample: Vision Screening Annual Report

Section F-6.3

TEXAS DEPARTMENT OF HEALTH

FOR INSTRUCTIONS:
See back of this form.

VISION SCREENING REPORT FOR SCHOOL YEAR 19__--19__

HEALTH
SCREENING
FACILITY _____

CITY _____

COUNTY _____

GRADES	A TOTAL NUMBER SCREENED	B SCREENED WITH GLASSES*	C NUMBER FAILED	D FAILED NOT REFERRED	E EXAMINED BY EYE SPECIALIST NO PROBLEM/ NO TREATMENT	F TREATMENT OR OBSERVATION	G REFERRED, NO FOLLOW-UP
PRE- SCHOOL SPECIAL EDUC.							
K							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

C = D + E + F + G

TOTALS	A	B	C	D	E	F	G

TOTAL EXAMINED BY EYE SPECIALIST
(E + F)

*This number is included in the total number screened and is, therefore, a smaller number.

To be submitted by: JUNE 30, 19__

To: Vision, Hearing and Speech Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756
(512) 458-7420

CHIEF ADMINISTRATOR'S SIGNATURE _____

CHIEF ADMINISTRATOR'S TITLE _____

DATE _____

M-62 (1983)

(Back of Report)

INSTRUCTIONS

VISION SCREENING REPORT FOR SCHOOL YEAR 19__--19__

Reporting Period: September through August of the year prior to the Reporting Date

Reporting Date: June 30th following the Reporting Period

EXPLANATION OF COLUMNS

Grades: This column is self-explanatory. For preschools and other organizations screening preschool-aged children, simply enter totals on the line for Preschool and enter those same totals on the TOTAL line.

Total Number Screened: Total number screened during the Reporting Period at each grade level

Screened With Glasses: Number screened with glasses on (This number is a part of the total number screened.)

Number Failed: Number who failed the screen or were referred for observable signs or symptoms. (This number should include those who fail other types of vision screens such as those used with stereoscopic instruments or other procedures, and at this time failure is determined by referral criteria associated with the particular screen.)

Failed Not Referred: Those who failed but are currently under an eye specialist's care OR those who have an uncorrectable condition (enucleated eyeball, etc.)

Examined by Eye Specialist: After examination by an eye specialist the following breakdown of results should be reported:

No Problem/No Treatment: Those referred who had no visual problem or who received no treatment for an existing condition

Treatment or Observation: Those referred who are receiving treatment from an eye specialist or whose conditions are being observed for a period of time

Referred, No Follow-Up: Those referred who did not see an eye specialist or who were lost to the screening program (This simply means that follow-up was not possible because either the person referred did not see an eye specialist or the information on the referral was unobtainable.)

REMEMBER: Calculate totals for each column at the bottom of the form and CHECK those totals using the simple formula given, $C = D + E + F + G$.

Also, note that columns E and F should be added together for a Total Number Examined by Eye Specialist.

Any questions about the proper use of this form can be directed to:

Vision, Hearing and Speech Services
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756
(512) 458-7420

Audiometric Screening

Section F-7.0

Audiometric Screening Consists of Three Methods of Testing

- Sweep-Check
- Puretone-Threshold
- Impedance

The Sweep-Check is a rapid screening test designed to identify students needing further examination. The Puretone-Threshold screening test, a more refined exam, is designed to determine the lowest intensity level of hearing acuity in each frequency. The Impedance test measures the transfer of sound energy across the middle ear mechanism. The resulting tympanogram reveals information about the condition of the middle ear.

Only audiologists, speech pathologists, or nurses with explicit training in the use of acoustic impedance audiometry should use this method of audiometric screening in the school.

Kindergarten and first and second grade children should be screened for hearing once a year. In the higher grades, vision and hearing tests may be alternated through the 11th grade. In addition, audiometric screening should include: students in special education classes; those referred by parent, counselor, or teacher; those known to have frequent ear infections; and those referred for follow-up who did not receive care. Local school district policy should determine grades designated for audiometric screening.

Purpose

- To identify through mass screening any student with possible hearing impairment.
- To identify the hearing-impaired child during early school years.
- To identify older students who have impaired hearing due to noise assault.
- To refer students for further audiometric screening or for medical evaluation and treatment.
- To teach hearing conservation and protection.

Procedures and Techniques

- The nurse should test the audiometer accuracy once a month.
- Students with draining ears or ear infections should be tested at a later date.
- Students wearing hearing aids should not be administered Sweep-Check or Puretone tests.
- The test location should provide the lowest noise level possible.
- Familiarize students with procedure, equipment, sounds, and expectations before testing.
- One-day hearing screening workshops are provided on a statewide basis by personnel from Vision, Hearing, and Speech Services or other Texas Department of Health-approved trainers. These workshops consist of half a day of lecture and half a day of practicum training in the use of the audiometer for screening. The practicum and a written test are carried out under the supervision of trained instructors. Guidelines are provided by the Texas Department of Health—Vision, Hearing, and Speech Services.

Follow-Up Procedures

- A student who fails to respond in either ear to two or more frequencies at 25 decibels, ANSI, should be re-tested at a later date.
- Students who fail audiometric re-testing should be referred to the school audioiologist, private physician, or community service. The audiogram should be provided to the referral agency.
- Teachers should be notified when students need preferential seating in the classroom.
- Families who cannot afford medical care should be referred to the Texas Department of Health, Division of Services for Crippled Children.
- Children with hearing problems, who cannot afford medical care, which require a hearing aid should be referred to the Texas Department of Health, Bureau of Maternal and Child Health—Vision, Hearing, and Speech Services.

Suggestions

- *Health Education:* In elementary schools, the nurse may include ear models, ear plugs, hearing aids, and an audiometer in classroom presentations. Discussions should include ear protection, noise levels or pollution, understanding of hearing loss, and hearing conservation. In secondary schools, nurses should also present information on audio protection from noise assault caused by loud machinery, musical amplifiers, musical headsets, hunting with guns, and motorcycles. All students should be taught not to put objects into ear canals. Outer ear cleaning is sufficient. Canal cleaning should only be done by physicians.
- *Arithmetic:* Elementary classroom presentation might include the decibel levels and frequencies used in audiometric screening.
- *Spelling:* Include anatomy of the ear with specialized words in spelling lists.

Factors Influencing Hearing/Types of Hearing Losses

- *Conductive:* Sound cannot reach the inner ear. Colds and allergies may cause temporary losses of this type.
- *Sensori-Neural:* A defect resulting from damage to the auditory nerve or brain.
- *Mixed:* A combination of conductive and sensory factors.

Conditions and Illnesses Affecting Hearing

- CONGENITAL DEAFNESS, SENSORI-NEURAL is caused frequently by illnesses in the first trimester of pregnancy (German measles, for example).
- HEREDITARY DEAFNESS is not rare. The cause is unknown.
- ACQUIRED DEAFNESS or hearing impairment may be caused by:
 - Meningitis, encephalitis, and other central nervous system infections.
 - Infections with neurotropic viruses such as mumps.
 - Infections of the ear—otitis media, mastoiditis.

- Toxic agents, such as nicotine, aspirin, streptomycin, neomycin, etc.
- Enlarged tonsils and adenoids, sinusitis, allergic rhinitis.
- Mechanical injury, including skull fracture; sustained environmental noise above 85 dB or loud impulse noise (rivet gun, air wrench, shotgun, rifle, etc.).
- Otosclerosis.
- Psychogenic (hysterical: conversion reaction).
- Central deafness, normal sense organ, and auditory nerve with impairment in the brain, i.e., tumors, cerebral hemorrhage.

Relationship of Degree of Impairment to Educational Needs Section F-7.1

Average of the Speech Frequencies in Better Ear	Effect of Hearing Loss on the Understanding of Language and Speech	Educational Needs and Programs
SLIGHT 27 to 40 dB (ISO/ANSI)	May have difficulty hearing faint or distant speech. May experience some difficulty with the language arts subjects.	Child should be reported to school principal and/or teacher. May benefit from a hearing aid. May need attention to vocabulary development. Needs favorable seating and lighting. May need lipreading instructions. May need speech therapy.
MILD 41 to 55 dB (ISO/ANSI)	Understands conversational speech at a distance of 3-5 feet (face to face). May miss as much as 50% of class discussions if voices are faint or not in line of vision. May exhibit limited vocabulary and speech anomalies.	Child should be referred to special education for educational follow-up. Individual hearing aid after evaluation and training in its use. Favorable seating and possible special class placement, especially for children in primary grades. Attention to vocabulary and reading. Lipreading instruction. Speech conservation and correction, if indicated.
MARKED 56 to 70 dB (ISO/ANSI)	Conversation must be loud to be understood. Will have increased difficulty in group discussions. Is likely to have defective speech. Is likely to be deficient in language usage and comprehension. Will have limited vocabulary.	Child should be referred to special education for educational follow-up. Resource teacher or special class. Special help in language skills: vocabulary development, usage, reading, writing, grammar, etc. Individual hearing aid after evaluation and auditory training. Lipreading instruction. Speech conservation and correction. Attention to auditory and visual situation at all times.

Relationship of Degree of Impairment to Educational Needs (Continued)

Average of the Speech Frequencies in Better Ear	Effect of Hearing Loss on the Understanding of Language and Speech	Educational Needs and Programs
SEVERE 71 to 90 dB (ISO/ANSI)	May hear loud voices about one foot from the ear. May be able to identify environmental sounds. May be able to discriminate vowels but not all consonants. Speech and language defective and likely to deteriorate.	Child should be referred to special education for educational follow-up. Full time special program for deaf children, with emphasis on all languages skills, concept development, lipreading, and speech. Program needs specialized supervision and comprehensive supporting services. Individual hearing aid after evaluation. Auditory training with individual and group aids. Part time in regular classes only as is profitable.
EXTREME 91dB or more (ISO/ANSI)	May hear some loud sounds but is aware of vibrations more than tonal pattern. Relies on vision rather than hearing as primary avenue for communication. Speech and language defective and likely to deteriorate.	Child should be referred to special education for educational follow-up. Full time in special program for deaf children, with emphasis on all language skills, concept development, lipreading, and speech. Program needs specialized supervision and comprehensive supporting services. Continuous appraisal of needs in regard to oral and manual communication. Auditory training with group and individual aids. Part time in regular classes only for carefully selected children.

Source: Adapted from a compiled study in Illinois Commission on Children, 1968, p. 19.

Hearing Conservation Program

Section F-7.2

Audiometer User Registration

Audiometer user registration is required under the Texas Regulations for the Control of Infrasonic, Sonic, and Ultrasonic Radiation. Specifications for registration can be met in two ways: an individual may qualify for registration (1) upon completion of six semester hours of audiology from an accredited institution, or (2) upon completion of a state-approved hearing screening workshop. (Physicians and licensed hearing aid dealers may be registered without prerequisite training.) A sample user registration form is provided in Section F-7.21.

Audiometric Workshops

Screening Workshops: One day screening workshops are provided on a statewide basis by personnel from Vision, Hearing, and Speech Services or other Texas Department of Health-approved trainers. These workshops consist of half a day of lecture and half a day of practicum training in the use of the audiometer for screening. The practicum, including a written test, is carried out under the supervision of the instructors.

Trainer Orientation Workshops

These workshops, provided by Vision, Hearing, and Speech Services, train persons who will conduct screening workshops throughout the state. Emphasis is on general format, materials, and techniques to be used by instructors. Equipment, materials, and required forms are provided.

Audiometer Registration

- The provisions of the *Texas Regulations for the Control of Infrasonic, Sonic, and Ultrasonic Radiation* also require registration of:
- All audiometers: Biological calibration monthly, electronic calibration annually, exhaustive electronic calibration at least every 5 years, all to current ANSI standards (see Section F-7.22).
 - All calibration firms: Calibration equipment, calibration technicians, training approved by, file reports as directed by the Texas Department of Health.

Sample: User of Audiometer Registration Form

Section F-7.21

Current Registration Number
(New Applicant Disregard)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

TEXAS DEPARTMENT OF HEALTH

USER OF AUDIOMETER REGISTRATION FORM(NOTE: This form will be copied as your REGISTRATION -- Please type or print plainly, in BLACK ink.)

APPLICANT'S NAME (First Name First)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

APPLICANT'S TITLE

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

APPLICANT'S ADDRESS (Street)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

APPLICANT'S CITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

STATE

--	--

ZIP CODE

--	--	--	--	--	--

EMPLOYER (Full Designation of Applicant's Fiscal Agent)
(If school please state whether Co-op, ISD, Consol., etc.)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

EMPLOYER'S ADDRESS (Street)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

EMPLOYER'S CITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

STATE

--	--

ZIP CODE

--	--	--	--	--	--

EMPLOYER'S TELEPHONE (Area Code + Number)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

EDUCATIONAL TRAINING (University, College or School Attended)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATES

--	--	--	--	--	--

DEGREE(S) EARNED

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

List Specific Audiometric Screening or Testing Courses Completed Under EDUCATIONAL TRAINING:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ADDITIONAL AUDIOMETRIC TRAINING:

AGENCY

Texas Dept. of Health
OSHA
Seminar
Other

NUMBER OF HOURS

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

APPLICANT WILL USE AUDIOMETERS IN: (Check Applicable Boxes) - Item

School Screening ☐ ; Speech Pathology ☐ ; Medical Research ☐ ;

Speech & Hearing Clinic ☐ ; Educational Training ☐ ;

Industrial Screening (OSHA) ☐ ; Medical Diagnostic ☐ ;

Fitting & Dispensing of Hearing Aids ☐ ; Health Agency ☐ ;

Other _____

APPLICANT'S SIGNATURE (Sign in BLACK ink)

Date: _____

FORMS MAY NOT BE REPRODUCED FOR APPLICATION USE
Additional Forms May be Requested

TRC Form 130-1, Part 1 (9-77)

Supersedes all previous TRC Forms 130-1, Part 1

AGENCY USE ONLY: REGISTRATION NUMBER _____

In accordance with statements and representations contained
in this application, you are hereby registered to use
audiometers (as indicated in ITEM 7) in the State of Texas.

D. K. Ozias, Ph.D., Director of Programs
Speech, Hearing and Vision
Division of Maternal and Child Health

Date: _____

Texas Department of Health

Texas Department of Health

Section F-7.22

Audiometer/Impedance Bridge Registration Application

TEXAS DEPARTMENT OF HEALTH

Audiometer/Impedance Bridge Registration Application

INSTRUCTIONS ON REVERSE

1. NAME OF OWNER		2. ADDRESS	
3. ADDRESS OF USE (if different from #2)		4. TELEPHONE NUMBER	
5. AUDIOMETER USAGE (check appropriate space(s)) school agency___; speech pathology___; health agency___; educational training___; industrial screening (OSHA)___; medical-research___; medical-diagnostic___; fitting & dispensing of hearing aids___; speech & hearing clinics___; other___			
6. DEPARTMENT OF USE:			
7. INDIVIDUAL(S) IN CHARGE OF UNIT AND TITLE:			
IDENTIFICATION			
8. MANUFACTURER:		9. MODEL NUMBER:	
		10. SERIAL NUMBER:	
11. TYPE OF CUSHIONS (check one): MX-41AR___; AURAL DOMES___; OTO CLIPS___; AUDIO CLIPS___; OTHER___		12. DATE OF LAST CALIBRATION:	
13. CALIBRATED BY (firm name and address):			
14. APPLICATION DATE:		15. PRINTED NAME:	
		16. TITLE:	
		17. SIGNATURE:	

RC Form 130-1, Part 2 (1-81) Supersedes all previous RC Forms 130-1, Part 2
AGENCY USE ONLY:

In accordance with statements and representations contained in this application, this audiometer/impedance bridge is hereby registered (as specified in ITEM 5 above) by the State of Texas.

D. K. Ozias, Ph.D., Director of Programs
Vision, Hearing and Speech Services
Division of Maternal and Child Health

REGISTRATION NO. _____

DATE _____

TEXAS DEPARTMENT OF HEALTH

(Back of Application)

**INSTRUCTIONS FOR AUDIOMETER/IMPEDANCE BRIDGE REGISTRATION APPLICATION
(TRC Form 130-1, Part 2)**

**PLEASE PRINT NEATLY IN BLACK INK OR TYPE ALL INFORMATION.
(Your registration will be a copy of this form.)**

NOTE: Your care in completing all required information in this application may save undue delay and reduce the amount of correspondence necessary. Your cooperation is earnestly solicited.

1. **NAME OF OWNER:** The name of the facility owning or leasing the audiometer/impedance bridge, or the name of the individual if the audiometer/impedance bridge is personally owned.
2. **ADDRESS:** Address of owner named in Item 1. Address must include city and zip code.
3. **ADDRESS OF USE:** Self-explanatory.
4. **TELEPHONE NUMBER OF APPLICANT:** Telephone number of owner named in Item 1 at place of employment; include area code.
5. **AUDIOMETER/IMPEDANCE BRIDGE USAGE:** Check appropriate space(s).
6. **DEPARTMENT OF USE:** Indicate specific office that audiometer/impedance bridge is used: i.e., Black and White Steel Mill - First Aid Station.
7. **INDIVIDUAL(S) IN CHARGE OF UNIT AND TITLE.** Individual(s) with administrative responsibility for use of the audiometer/impedance bridge and given title(s).
8. **MANUFACTURER:** Company that made the audiometer: i.e., Beltone, Maico, etc.
9. **MODEL NUMBER:** Manufacturer's model designation number: i.e., 9D, MA-2, etc.
10. **SERIAL NUMBER:** Manufacturer's serial number: NOT A LOCALLY ASSIGNED INVENTORY OR OTHER RECORD NUMBER! (Serial number is usually found on data plate next to model number.)
11. **TYPE OF CUSHIONS:** Type of cushions on earphones; check appropriate space.
12. **DATE OF LAST CALIBRATION:** Self-explanatory.
13. **CALIBRATED BY:** List the name and address of the firm that last calibrated the audiometer/impedance bridge.
14. **APPLICATION DATE:** Date form is completed by applicant listed in Item 1.
15. **PRINTED NAME:** Printed name of individual submitting application.
16. **TITLE:** Title of individual listed in Item 15.
17. **SIGNATURE:** Signature of individual listed in Item 15. Must be signed in black ink.

BE SURE TO REGISTER ALL AUDIOMETERS/IMPEDANCE BRIDGES USED. SEPARATE FORMS ARE REQUIRED FOR EACH AUDIOMETER/IMPEDANCE BRIDGE REGISTERED. FORMS MAY NOT BE REPRODUCED FOR APPLICATION USE. ADDITIONAL FORMS MAY BE REQUESTED FROM THIS DEPARTMENT.

MAIL THIS APPLICATION TO: Texas Department of Health
Vision, Hearing and Speech Services
1100 West 49th Street
Austin, Texas 78756

Scoliosis Screening

Section F-8.0

Scoliosis is a lateral curvature of the spine, most commonly found during the adolescent growth period. It is estimated that between five and ten percent of school children have a curvature in varying degrees. However, only about two percent are significant. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly treatment is received.

Scoliosis is more common in girls than in boys. The malformation tends to progress no further once the spine has reached full growth, about the age of 15 for girls or 17 for boys.

Purpose

The purpose of scoliosis screening is the early detection and referral of spinal variations which may or may not be progressive. If detected early, a vertebral curvature may be controlled. Any spinal deviation of a student should be referred by the school nurse for follow-up care by the family physician, orthopedist, public clinic, or hospital.

Nurse Responsibilities

The school nurse must be well prepared to provide the maximum benefit for the students in a scoliosis screening program. Grades five through nine should be screened.

- Orient the school staff, parents, and students to scoliosis screening procedures.
- Provide school personnel, other nurses, physical education teachers, and aides or volunteers with a workshop on scoliosis screening.
- Inform parents or guardians and local physicians in writing of the planned screening. Any student should be exempted from examination upon written request of a parent or guardian.
- Select a private screening site and a date agreeable with individual school principals.
- Plan for re-screening of students found with positive indications of spinal curvature.
- Plan for student referral to private physicians, orthopedists, public clinics, or hospitals.
- Follow-up on student referrals; place physician statements in permanent files.
- Notify involved school personnel of physician's positive diagnosis of any student.

Organization

The school nurse will need to coordinate the following organizational activities closely with the principal and involved teachers:

- Students will be screened separately in an environment offering privacy. If possible, locate the screening area where students can change clothing in privacy. A room adjacent to the physical education dressing room might be most convenient.
- Determine the number of students to be screened per class, and determine whether separate days (one for boys; one for girls) or only one day will be needed. (One nurse can screen approximately 25 students per class hour.)
- If a parent contacts the school and would prefer *not* to have a child screened, be sure to privately identify the students.
- Remind students the day before scheduled screening. Some may wish to bring a change of clothing.

- Each screener will need a chair. There should also be a table nearby for use in recording information. The screeners should be five to eight feet from the subject. Place a strip of tape on the floor to mark the place the student is to stand. Good lighting will facilitate the screening.
- The student's back should be exposed as completely as practical. Girls should wear a bra or halter. Leotards and one piece swimsuits tend to camouflage the lower spine area.

Procedures and Techniques

- Student stands with *back to screener* with clothing loosened or removed to expose back. Screener checks for the following:
 - Unequal shoulder levels.
 - Symmetry of scapulae.
 - Symmetry of flanks.
 - Uneven or greater crease at one side of waist.
 - Unequal distance between body and the elbow when both arms are hanging straight down from shoulders.
- Student bends forward 90° at waist, *back to screener*, feet together, knees straight, and arms hanging in front with palms together. Observe for thoracic rib hump.
- Student *faces screener* and bends at 90° at the waist, feet together, knees straight, and arms hanging in front with palms together. Observe for lumbar hump and levels of back on both sides of the spine.
- Student *turns to side*, bends, while screener checks symmetry of both sides of the spine and looks for a smooth continuous curve of spine. Side-standing position: observe for lordosis or kyphosis.
- Record findings (see Section F-8.2).

Re-Screening

- At a separate session, re-screen all positive findings to verify original findings. Use the original control form at the re-screening. A second opinion from another school nurse is helpful.
- Since scoliosis tends to run in families, screening the siblings of children with known scoliosis is a good idea, particularly if members are eight years of age or older.
- Keep a list of students with questionable findings and arrange a second screening in four to six months.

Referral

- Students with positive findings at the re-screening should be referred to a private physician, orthopedist, public clinic, or hospital for a follow-up.
- A letter should be sent to the parent or guardian, along with a letter to the private physician, for every student with abnormal findings.
- Send a copy of the nurse screening form or diagrams to the private physician, orthopedist, public clinic, or hospital noting area(s) of concern.

Recording and Follow-Up

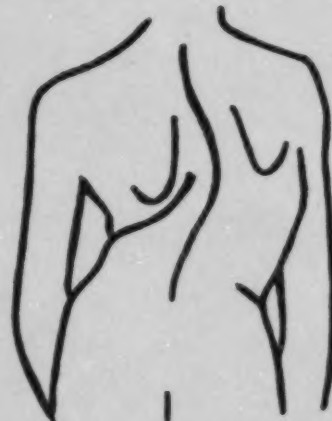
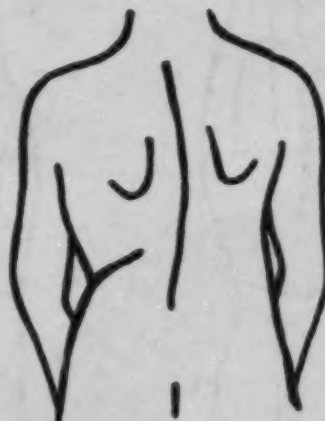
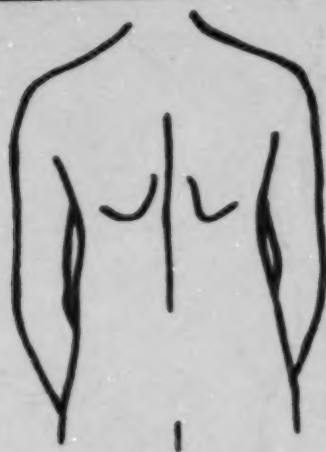
- Notation should be made on student health records of screening date and findings.
- Follow-up must be made through individual students or parents. Every effort should be made to encourage parents to follow through on referrals. Note efforts made regarding follow-up and physician diagnosis on records.

Facts About Scoliosis

- Idiopathic scoliosis: Lateral curvature of the spine with rotation of the vertebra. Cause unknown.
- Occurs eight times as often in girls as boys.
- Tends to be hereditary.
- Usually no discomfort or injury is evident, so there will be no warning.
- Can result in physical distortions if not treated.
- Can be identified without a great deal of special training.
- Signs become recognizable during preteen and teen years.
- Most often found by non-medical people due to signs such as clothing not fitting well, one shoulder or hip being higher, carrying the head in a noticeably different manner, or one leg seeming to be short, etc.
- Early identification is beneficial to the treatment program.
- Potentially can continue to get worse as long as the student continues to grow.
- Scoliosis cannot be cured but can be managed so that it does not turn into a problem, in most cases.
- X-rays are necessary to get an accurate measure of the curve at any given time.
- Bracing and exercises are the generally accepted means of treatment if the degree of curve indicates the need.
- May need surgery if it progresses.
- Can cause death in extreme cases.

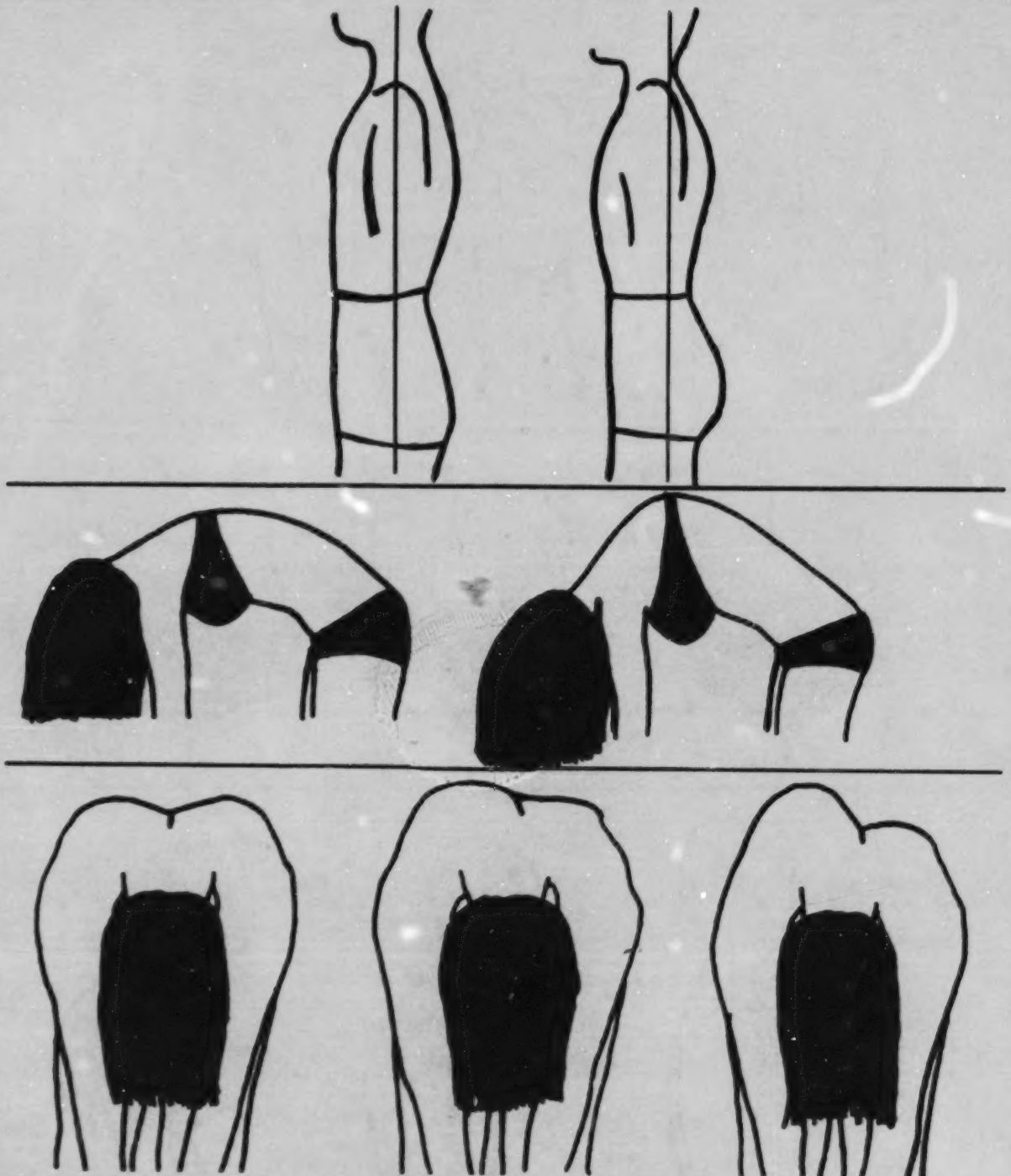
Drawings for Scoliosis Screening

Section F-8.1



Drawings for Scoliosis Screening

Section F-8.1





Scoliosis Screening Worksheet

Section F-8.2

Name _____ Age _____ Date _____ M/F _____

Address _____ School _____ Grade _____

Parent/Guardian Name _____

Examiner Name/Title _____

Back to examiner

- | | | |
|---|---------|---------|
| 1. Head and neck base off center over sacrum? | R _____ | L _____ |
| 2. Shoulder level uneven? Higher side? | R _____ | L _____ |
| 3. Shoulder blades uneven? Higher side? | R _____ | L _____ |
| 4. Waist creases uneven? Higher side? | R _____ | L _____ |
| 5. Obvious spinal curvature? | R _____ | L _____ |
| 6. Arm to body space unequal? | R _____ | L _____ |

Back toward examiner—Bent forward

- | | | |
|-----------------------------------|---------|---------|
| 7. Rib prominence on one side? | R _____ | L _____ |
| 8. Lumbar prominence on one side? | R _____ | L _____ |

Side toward examiner—View both sides—Standing and bent over

- | | | | |
|--------------------------------------|------------|------------|--------------|
| 9. Increased Roundback? | Slt. _____ | Mod. _____ | Severe _____ |
| 10. Increased Swayback? | Slt. _____ | Mod. _____ | Severe _____ |
| 11. Thoracic prominence on one side? | | R _____ | L _____ |
| 12. Lumbar prominence on one side? | | R _____ | L _____ |

Facing examiner

- | | | |
|---|---------|---------|
| 13. Shoulder level uneven? Higher side? | R _____ | L _____ |
| 14. Hip prominences unequal? Higher side? | R _____ | L _____ |
| 15. Arm to body space unequal? | R _____ | L _____ |

Facing examiner—Bent forward

- | | | |
|------------------------------------|---------|---------|
| 16. Lumbar prominence on one side? | R _____ | L _____ |
| 17. Rib prominence on one side? | R _____ | L _____ |

Is student presently under treatment for scoliosis? No _____ Yes _____

If yes, Doctor's name: _____

**Scoliosis Screening Worksheet**

(Back of Page: Scoliosis Screening Worksheet)

Re-check in six months: No _____ Yes _____

Referred to: School physician _____

Family physician _____

Orthopedist _____

Clinic _____

Seen by physician: No _____ Yes _____

No problem _____

Referred to specialist _____

Diagnosis _____

Treatment _____

Re-check? No _____ Yes _____ When? _____

Follow-up by school nurse, and outcome:

Student _____

Parent _____

Physician _____

Hypertension Screening

Section F-9.0

Hypertension is a significant public health problem in the United States. Prevalence rates vary by age, race, nutrition, environmental stresses, and certain physical health problems. Hypertension usually begins insidiously, seldom causing symptoms until it is well established. Hypertension may be asymptomatic.

Purpose

The purpose of a hypertension screening program in the school should be the early identification of students with consistently elevated blood pressure, with appropriate follow-up procedures. In most cases, early detection of hypertension is an aid in control leading to improved health and longer life.

Procedures and Techniques

- Educate students and staff regarding hypertension. Terminology should be kept simple for student understanding.
- Seat the child facing the screener with the forearm suitably bared, flexed, and resting on a table so the cuff will be placed at the level of the right atrium. The dial of the aneroid or mercury column should be placed so it can be read at eye level.
- Apply the appropriate size cuff with the center of the rubber bladder over the brachial artery, leaving a space of about 1 cm between the bottom of the cuff and the antecubital area.
- Locate the radial artery pulse by palpation, inflate the cuff to about 30 mm Hg above the pressure at which the radial pulse disappears. Then deflate the cuff at a rate of approximately 2 mm Hg/second. Note the level at which the radial pulse returns. Deflate cuff and wait 15 seconds.
- Locate the brachial artery pulse by palpation, place the diaphragm of the stethoscope over the artery. Rapidly inflate the cuff to a pressure approximately 30 mm Hg level at which the radial pulse was identified. Deflate the cuff gradually (2 mm/sec) until the first clear tapping sound is heard (Korotkoff sound, Phase I). Record this point as the systolic pressure. Continue to deflate the cuff while the sound becomes clearer, louder, and crisper, then suddenly changes to a low-pitched muffled one (Phase IV), then disappears (Phase V). Record Phase IV and V. Use Phase IV the point at which the sound changes, as the standard for referral (i.e., 120/80/60).
- Repeat the auscultation method to assure accuracy and allow student time to relax as the procedure becomes familiar. Verify your recording.
- Inform the student of the findings and the nature of any referral or follow-up that may be necessary. Allow student time to ask questions.

Equipment

- Mercury or aneroid sphygmomanometer. The mercury type is more reliable, accurate, and causes of error can be determined visually. It must be kept clean, glass tube free of dust, and the mercury reservoir properly filled. The aneroid manometer is less bulky but requires more frequent calibration versus a mercury manometer.
- Compression Cuff. One or more cuffs suitable to the age of students and staff are needed. The cuff must cover $\frac{2}{3}$ of the length of the upper arm, and the rubber bladder should encircle its girth.
- Stethoscope. Check stethoscope regularly to assure that earpieces are clean and that the diaphragm is intact.

Dimensions for Appropriate Size Cuff

Name	Width (cm)	Length (cm)
Newborn	2.5 - 4.0	5.0 - 10.0
Infant	6.0 - 8.0	12.0 - 13.5
Child*	9.0 - 10.0	17.0 - 22.5
Adult*	12.0 - 13.0	22.0 - 23.5
Large adult*	15.5	33.0
Adult thigh	18.0	36.0

*It is suggested these sizes be available for school use.

Normal Blood Pressure Ranges

6 years and under	78/48 - 114/80
7 - 9 years	82/52 - 120/80
10 - 12 years	90/58 - 134/84
13 - 49 years	90/60 - 140/90
50 years and older	90/60 - 160/95

Standards for Referral

- If either the systolic or diastolic reading is higher than the above levels, allow student to rest about 15 minutes and recheck. If the readings are still higher than the chart levels, recheck on another day.
- Diastolic pressure of 100 mm Hg or above should be confirmed and referred for prompt medical evaluation.
- A student with systolic or diastolic pressure above the normal range should have referral made to parent or guardian. Assistance should be offered if help is needed in obtaining medical follow-up.
- Group counseling might be effective if there are a number of students on the secondary level with blood pressure variations.

Follow-Up Procedures

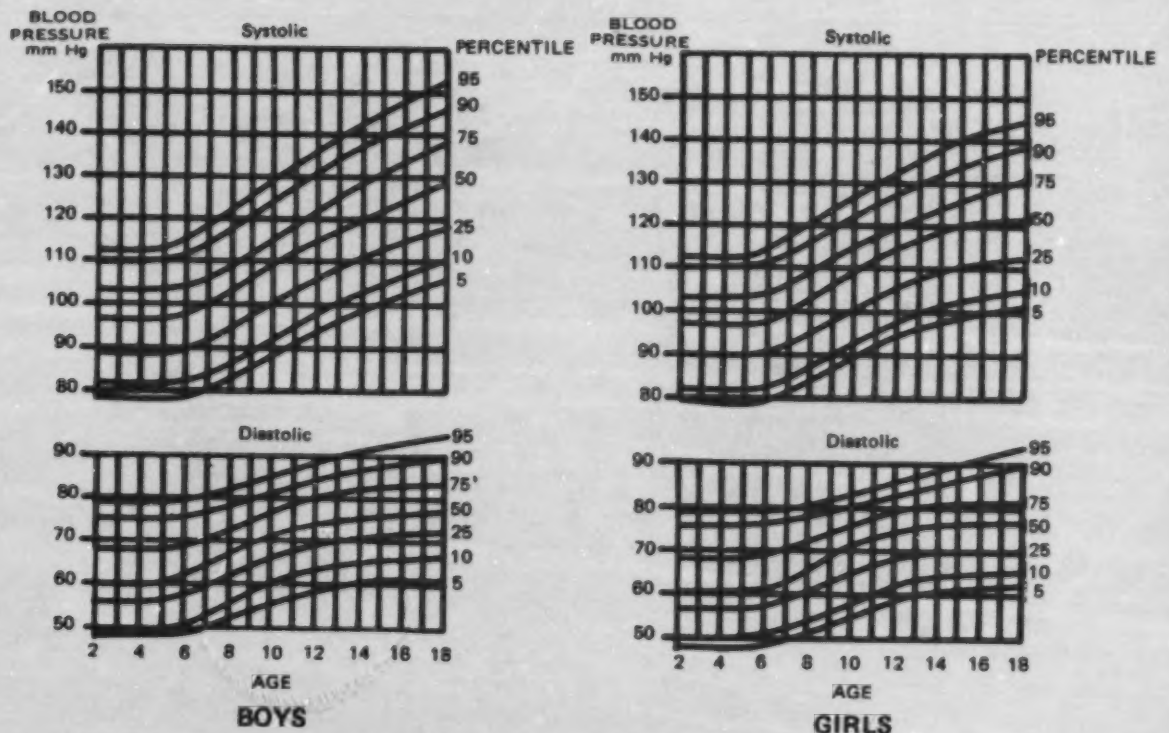
- Hypertension screening program letters should be prepared by local school districts.
- Parent or guardian of hypertensive students should be notified personally of findings. Parent education regarding hypertension should be provided.
- Continued monitoring should be provided if requested by the private physician.
- Parents, students, and staff should be emphatically made aware that school hypertension screening is not in lieu of a physician's care.
- Medication may be prescribed. The nurse should be available to administer and monitor such medication in accordance with local school board policy.
- All students with blood pressure variation should be re-screened once a year. Severity of the problem may indicate a need for more frequent checks.
- The nurse should not hesitate to discuss hypertension findings with a student's private physician.

Suggestions

- **Health Education:** Hypertension screening provides an excellent opportunity for teaching the cardiovascular system. The unit could include detailed explanation of the procedure, equipment used, normal range, significance of an elevation in blood pressure, the factors which affect blood pressure, along with importance of prevention and treatment.

Percentiles of Blood Pressure Measurement

Section F-9.1



"Report of the Task Force on Blood Pressure Control," *Pediatrics*, 59(5): Part 2, May 1977.

Section G Accountability

Section G Accountability

Accountability

School health services shall be considered as part of the educational program of the school children of Texas. These services shall be provided to all children through local education agencies, in accordance with the provisions of Subchapter D of Chapter 97 of this title (relating to Principles, Standards, and Procedures for the Accreditation of School Districts), and standards established by the Texas State Department of Health and in accordance with applicable laws. The local education agency shall ensure appropriate coordination of school health services, other student services, and related instructional programs (Texas Administrative Code §85.41).

Purpose

The purpose of accountability is to document the role of health services in the delivery of health care, to evaluate the efficacy of practices, and to modify or discontinue those practices shown to have no effect on the health status of individuals.

Role

School nurses are well-qualified to assume responsibilities of planning, coordinating, implementing, and evaluating a school health program. If nurses assume this responsibility, then accountability for services provided must be accepted. Documentation and evaluation of health services provides a means toward accountability. The school nurse has:

- The expertise to detect and assess student health problems, especially at an early stage.
- The expertise and time needed to effectively follow up identified health problems, to provide health counseling to students and parents, and to motivate and help parents obtain appropriate health care for children.
- The ability to guide school administrators and teachers in modifying the school regimen and environment to meet special health needs of students.
- The knowledge to deal effectively with major emergency injuries and illnesses of students, individually or on a mass disaster basis.
- The ability to coordinate community public and private resources to help implement the total school health program.
- The knowledge to assist in the safe placement of handicapped students into the mainstream of education.
- The skill to make valid referrals to private or community resources. (Over-referrals involve unnecessary expense to parents.)
- The insight to identify health and safety hazards within the school which could endanger health or lives and reduce both the level of student ability to learn and faculty ability to teach.
- The proficiency to make an impact on Average Daily Attendance (ADA) by reducing the possibility of communicable disease and promoting high level wellness.
- The broad based health background to serve as a resource person to administrators and teachers.

School nurses may easily prepare documentation representing accountability to the school district. Documentation is basic to the registered nurse and may be readily adapted to the school setting. The school nurse, through health service, must be prepared to present the end result of planning, implementation, and evaluation to administration (see Accountability forms, Section CC).

Section H

Inservice Education

Section H	Inservice Education
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Inservice Education

Under the Texas Education Code §16.052, a school district must provide for not less than eight days of inservice training and preparation for school nurses. Not more than three of the eight days may be used as staff preparation (work) days. All professionals and paraprofessionals, except clerical aides, must participate in the inservice program. School districts may seek assistance from the regional education service centers, the Texas Education Agency, institutions of higher education, local or state health departments, or local community resources in selecting education activities which promote professional growth.

Purpose

The purpose of the guidelines is to help school districts and education service centers plan effective inservice programs consistent with state law and State Board of Education rules.

Definition

Inservice education, as defined by the State Board of Education, is "a planned program of learning opportunities afforded staff members of school districts and related agencies for purposes of improving performance in already held or assigned position."

Staff development, which is a broader term, is usually defined to include manpower planning, staffing, organizational activities, and graduate education.

A. The essential provisions of effective inservice education programs include the following:

1. Learning opportunities are provided.
2. Purposes of the inservice program are defined and related to improving performance.
3. Inservice activities address assigned jobs or positions.
4. Planned activities provide assurance of accountability for predetermined outcomes.

B. Acceptable inservice activities

The definition of inservice education permits and, in turn, restricts certain activities. Acceptable inservice activities shall include the following:

1. Any planned activity designed to produce new and/or improved performances in job assignments.
2. Activities which lead to degrees or certification, provided such credentials are not the primary purpose of the inservice.
3. Activities planned as part of the local program regardless of time, place, or persons involved.
4. The development of curriculum materials for use on the job.
5. Training activities directed toward changes in role expectations and responsibilities.
6. Evaluation activities which have as a primary objective improved performance in job assignments.
7. Communication activities designed to disseminate information among staff members and orient new staff.

C. Limitations on inservice education activities

Activities which do not fall within the scope of the definition for inservice education shall include the following:

1. Formal preparation programs directed toward new certification, advanced degrees, or specialized training for future positions rather than for improvement of performance on the current job assignment.
2. Incidental activities from which learning may be derived but for which there is no specific plan.
3. Routine activities offering no specific training opportunities for improved performance in already held or assigned positions.

Texas Education Agency, *A Guide to Better Inservice Education in Texas*, Bulletin GE2 311 01 (Austin: The Agency, 1982), p. 2.

Section AA

Resource Organizations and Literature

Section AA	Resource Organizations and Literature
	1.0 Organizations
	2.0 Executive Directors, Education Service Centers
	3.0 Local Health Departments
	4.0 Texas Department of Health Offices
	5.0 Literature

Health-related information from recognized organizations provides resources for the school nurse. The following lists of organizations, education service centers, health departments, and literature contain suggestions which may be helpful in the collection of health materials.

The school nurse has a cooperative relationship with several agencies, such as the Texas Education Agency, Texas Department of Health, and the Texas Department of Human Resources. The agencies provide information for nurse practice, supplies, films, and literature for health education. The nurse, in return, provides state agencies with data regarding immunization, communicable disease, and screenings.

Resource material used in a school health program or by a school nurse should be carefully reviewed and evaluated prior to use. It must be appropriate, current, and provide accurate information. Materials obtained from private industry or organizations must be evaluated for educational content. It should not be used in product promotion.

Organizations

Section AA-1.0

U.S. Public Health Service-Division of *Accident* Prevention:
800 North Quincy Street, Arlington, Virginia 22203.

National Clearinghouse for *Alcohol* Information:
P.O. Box 2345, Rockville, Maryland 20852.

Texas Association for the Prevention of *Alcohol* and *Drug Abuse*, Inc.:
1801 Lavaca, Austin, Texas 78701; (512) 474-1426.

National Council on *Alcoholism*:
Two East 103rd Street, New York, New York 10029.

Arthritis Foundation, The:
3400 Peachtree Road NE, Atlanta, Georgia 30326.

Texas Society for *Autistic* Citizens:
1200 Guadalupe, Austin, Texas 78701; (512) 472-1454.

March of Dimes—*Birth Defects* Foundation:
P.O. Box 2000, White Plains, New York 10602.

March of Dimes—*Birth Defects* Foundation (Texas Regional Office):
2527 Royal Lane, Suite 155, Dallas, Texas 75229; (214) 620-9779.

American Foundation for the *Blind*:
15 West 16th Street, New York, New York 10011.

State Commission for the *Blind*:
P.O. Box 12866, Austin, Texas 78711; (512) 475-1791.

National Society to Prevent *Blindness*:
79 Madison Avenue, New York, New York 10016.

Texas Society to Prevent *Blindness*:
10007 West 31st Street, Austin, Texas 78751; (512) 451-3732.
P.O. Box 13400, Houston, Texas 77019; (713) 526-2559.

American *Cancer* Society:
777 Third Avenue, New York, New York 10017.

American *Cancer* Society—Texas Division:
P.O. Box 9863, Austin, Texas 78766; (512) 345-4560.

United *Cerebral Palsy* Association, Inc.:
66 East 34th Street, New York, New York 10016.
United *Cerebral Palsy* Association of Texas, Inc.:
7801 North Lamar, Austin, Texas 78757; (512) 458-8161.

National Society for *Crippled* Children and Adults, Inc.:
2023 West Ogden Avenue, Chicago, Illinois 60612.

Cystic Fibrosis Foundation:
6000 Executive Blvd., Suite 309, Rockville, Maryland 20852.

Organizations

Section AA-1.0

National Dairy Council:

6300 North River Road, Rosemont, Illinois 60018.

National Association for the Deaf:

814 Thayer Avenue, Silver Spring, Maryland 20910.

National Association for the Deaf/Blind:

2703 Forest Oak Circle, Norman, Oklahoma 73071.

American Dental Association:

211 East Chicago Avenue, Chicago, Illinois 60611.

Texas Dental Association:

1946 S. Interregional Hwy., Austin, Texas 78704; (512) 443-3675.

Texas Department of Health—Bureau of Dental Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7323.

American Diabetes Association:

Two Park Avenue, New York, New York 10016.

American Diabetes Association—North Texas Affiliate:

5415 Maple Avenue, Dallas, Texas 75235; (214) 638-5400.

American Diabetes Association—South Texas Affiliate:

P.O. Box 14926, Austin, Texas 78761; (512) 454-7614.

American Dietetic Association:

430 North Michigan Avenue, Chicago, Illinois 60611.

Texas Dietetic Association:

900 Old Koenig Lane, Austin, Texas 78751; (512) 458-6728.

National Clearinghouse for Drug Abuse Information:

P.O. Box 2305, Rockville, Maryland 20852.

Texas Education Agency:

201 East 11th Street, Austin, Texas 78701; (512) 834-4000.

Epilepsy Foundation of America:

1828 L Street NW, Suite 406, Washington, DC 20036.

National Health Information Clearinghouse, NHIC, (*Health Calendar*):

P.O. Box 1133, Washington, DC 20013; 1-800-336-4797.

Texas Department of Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7111.

Texas Education Agency, TEA, *Health Services Consultant*:

201 East 11th Street, Austin, Texas 78701; (512) 834-4081.

U.S. Department of Health and Human Services—Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine:

Hubert H. Humphrey Building, 200 Independent Avenue SW, Washington, DC 20201.

Organizations

Section AA-1.0

American Heart Association:

7329 Greenville Avenue, Dallas, Texas 75231; (214) 750-5300.

American Heart Association—Texas Affiliate, Inc.:

P.O. Box 15186, Austin, Texas 78761; (512) 836-7220.

Texas Department of Human Resources:

1708 East Anderson Lane, Austin, Texas 78752; (512) 441-3355.

American Humane Association—Children's Division:

P.O. Box 1266, Denver, Colorado 80201.

Kidney Foundation:

Two Park Avenue, New York, New York 10016.

Kidney Foundation of Texas:

13500 Midway, Dallas, Texas 75234; (214) 934-8057.

Texas Association for Children with Learning Disabilities:

1011 West 31st Street, Austin, Texas 78756; (512) 458-8234.

Leukemia Society of America:

800 Second Avenue, New York, New York 10017.

118 Broadway, San Antonio, Texas 78205; (512) 225-4404.

Texas Department of Health, Life Program, Bureau of Chronic Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7534.

American Lung Association:

1704 Broadway, New York, New York 10019.

American Lung Association of Texas:

7701 North Lamar, Suite 104, Austin, Texas 78752; (512) 458-2206.

Texas Department of Health, Bureau of Maternal and Child Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7770.

American Medical Association:

535 North Dearborn Street, Chicago, Illinois 60610.

Texas Medical Association:

1801 North Lamar, Austin, Texas 78756; (512) 477-6704.

Texas Department of Mental Health-Mental Retardation:

P.O. Box 12668, Austin, Texas 78711; (512) 454-3761.

National Multiple Sclerosis Society—Public Relations Department:

257 Park Avenue South, New York, New York 10017.

Muscular Dystrophy Association, Inc.:

810 Seventh Avenue, New York, New York 10019.

Muscular Dystrophy Association:

7718 Wood Hollow, Austin, Texas 78731; (512) 345-3800.

Organizations

Section AA-1.0

American Nurses Association:

2420 Pershing Road, Kansas City, Kansas 64108.

1030 15th Street NW, Washington, DC 20005.

Texas Nurses Association:

314 Highland Mall Blvd., Suite 504, Austin, Texas 78752; (512) 452-0645.

Texas State Board of Nurse Examiners—Registered Professional Nurses:

1300 East Anderson Lane, Austin, Texas 78752; (512) 835-4880.

National League for Nursing:

28 Westfall Road, Rochester, New York 14620.

Society for Nutrition Education:

1736 Franklin Street, Oakland, California 94612.

Texas Association of Optometrists:

1220 Colorado, Austin, Texas 78701; (512) 478-3753.

Planned Parenthood Federation of America:

810 Seventh Street, New York, New York 10019.

Planned Parenthood Education Center:

1703 East Seventh Street, Austin, Texas 78702; (512) 472-0868.

Parents Anonymous:

24-hour toll free hotline; 1-800-421-0353.

American Academy of Pediatrics:

P.O. Box 1034, Evanston, Illinois 60204.

American Public Health Association:

1015 18th Street NW, Washington, DC 20036.

Texas Public Health Association:

8140 Burnet Road, Austin, Texas 78756; (512) 451-0846.

American National Red Cross:

17th and D Streets NW, Washington, DC 20006.

2300 McKinney, Dallas, Texas 75201; (214) 741-4421.

P.O. Box 397, Houston, Texas 77001; (713) 424-5050.

Texas Rehabilitation Commission:

118 East Riverside Drive, Austin, Texas 78704; (512) 447-0163.

Texas Association for Retarded Citizens:

833 Houston Street, Austin, Texas 78701; (512) 454-6694.

National Runaway Switchboard:

24-hour toll free hotline; 1-800-621-4000.

National Safety Council—Director of Public Information:

425 North Michigan Avenue, Chicago, Illinois 60611.

Organizations

Section AA-1.0

American School Health Association:

P.O. Box 708, Kent, Ohio 44230.

Texas School Health Association, c/o American Heart Association:

Attention: Betty Tevis, 7320 Greenville, Dallas, Texas 75231; (214) 748-7212.

Texas State Teachers Association—School Health Section for Nurses:

316 West 12th Street, Austin, Texas 78701; 1-800-252-9673 or (512) 476-5355.

National Association of School Nurses:

New York Statler Hotel, Suite 104, New York, New York 10001.

National Educational Association—Department of School Nurses:

1201 16th Street NW, Washington, DC 20036.

National Scoliosis Foundation, Inc.:

48 Stone Road, Belmont, Maine 02178.

National Clearinghouse on Smoking and Health Center for Disease Control:

Atlanta, Georgia 30333.

Texas Speech and Hearing Association:

1209 West 34th Street, Austin, Texas 78756; (512) 452-8278.

Texas Department of Health, Speech and Language Screening:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7420.

American Speech, Language, and Hearing Association:

10801 Rockville Pike, Rockville, Maryland 20852.

American Association of Suicidology (AAS):

Central Office: 2459 South Ash, Denver, Colorado 80222.

Tattle Tooth Program, Bureau of Dental Health, Texas Department of Health:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7111.

Toughlove:

Community Services Foundation, Box 70, Sellersville, Pennsylvania 18960.

2208 Brookhill Drive, Austin, Texas 78745; (512) 442-1198.

Texas Department of Health, Vision, Screening Programs:

1100 West 49th Street, Austin, Texas 78756; (512) 458-7420.

Texas Board of Vocational Nurse Examiners:

1300 East Anderson Lane, Austin, Texas 78752; (512) 835-2071.

Executive Directors, Education Service Centers

Section AA-2.0

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Telephone: (713) 462-7708

REGION V

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2295 Delaware Street
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REGION VI

Mr. Max W. Schlotter
Region VI Education Service Center
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REGION VII

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Kilgore, Texas 75662
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Telephone: (214) 984-3071

REGION VIII

Mr. Scott Ferguson
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100 North Riddle Street
Mt. Pleasant, Texas 75455
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REGION IX

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REGION X

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REGION XII

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Austin, Texas 78752
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REGION XIV

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Region XV Education Service Center
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REGION XVI

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Amarillo, Texas 79102
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Telephone: (806) 376-5521

REGION XVII

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Region XVII Education Service Center
4000 22nd Place
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Telephone: (806) 792-4000

REGION XVIII

Dr. J. W. Donaldson
Region XVIII Education Service Center
P. O. Box 6020
Midland, Texas 79701
Location: LaForce Boulevard
Telephone: (915) 563-2380

REGION XIX

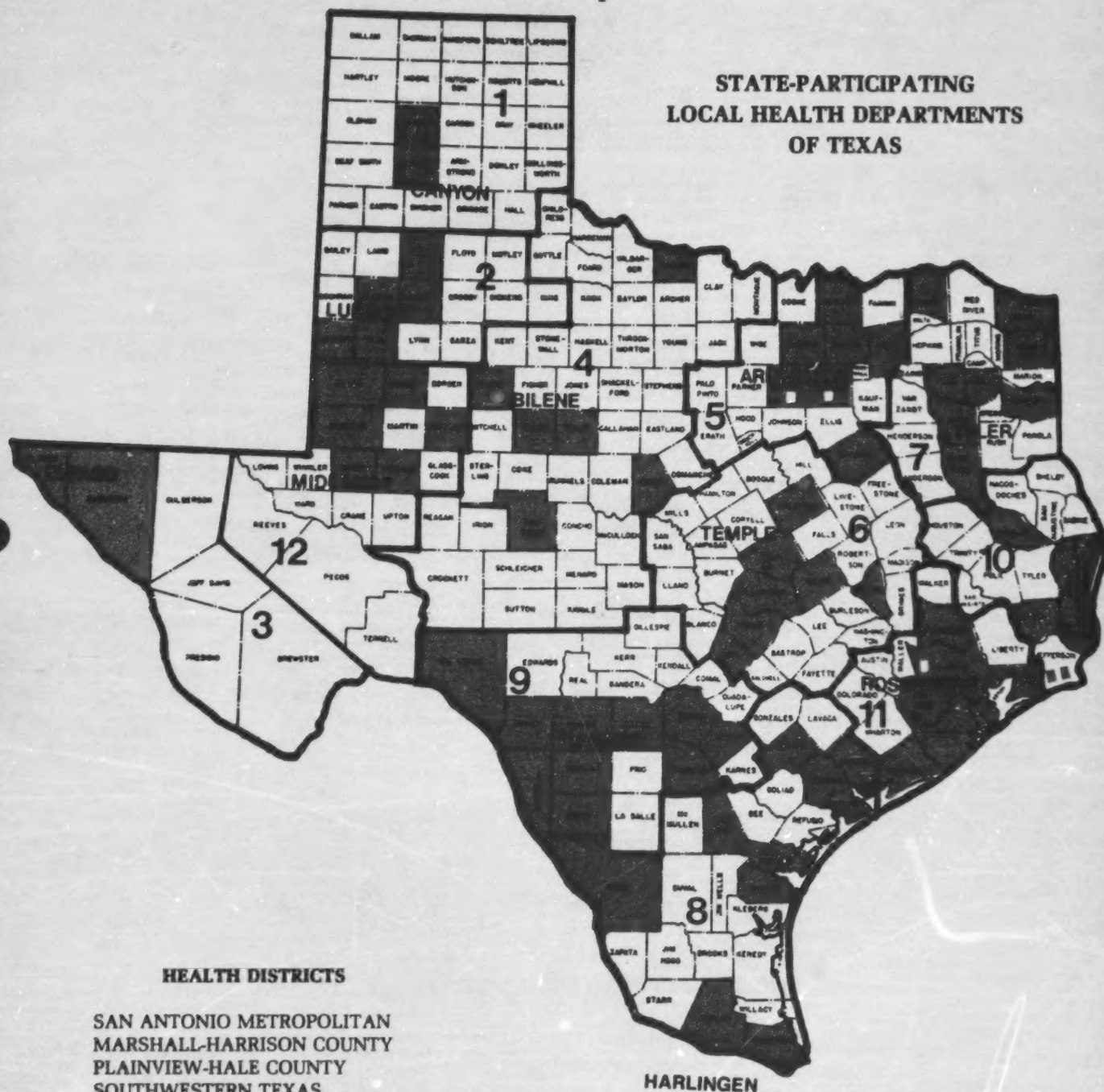
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REGION XX

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1314 Hines Avenue
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Local Health Departments

Section AA-3.0

STATE-PARTICIPATING
LOCAL HEALTH DEPARTMENTS
OF TEXAS

- CITY-COUNTY DEPARTMENTS
- CITY DEPARTMENTS
- REGIONAL HEADQUARTERS

Texas Department of Health Offices

Section AA-4.0

Texas Department of Health

December 1982

(512/456-7111)

- COMMISSIONER OF HEALTH**
Office of General Counsel
Office of the BOARD OF HEALTH
- DEPUTY COMMISSIONER FOR PROFESSIONAL SERVICES**
Public Health Promotion Division
- DEPUTY COMMISSIONER FOR MANAGEMENT & ADMINISTRATION**
Internal Audit
Bureau of Personnel Management
- ASSOCIATE COMMISSIONER FOR COMMUNITY & RURAL HEALTH**
Bureau of Community Health Services
Local Health Services Division
Hospital Care Division
San Antonio Chest Hospital
Harrington Chest Hospital
Public Health Nursing Division
Regional Programs
- ASSOCIATE COMMISSIONER FOR PERSONAL HEALTH SERVICES**
Bureau of Dental Health
Bureau of Crippled Children's Services
Crippled Children's Services Program
Adult Assistance Program
SSI-Disabled Children's Program
Early Childhood Intervention Program
Bureau of Maternal and Child Health
Child Health Division
Maternal Health and Family Planning Division
Bureau of Chronic Diseases
Adult Health Services Program
Kidney Health Care Program
Bureau of Emergency Management
Emergency Medical Services Division
Medical Standards on Motor Vehicle Operations Division
Disaster Response Program
- ASSOCIATE COMMISSIONER FOR PREVENTABLE DISEASES**
Bureau of Communicable Disease Services
Immunization Division
Infectious Disease Control Division
Tuberculosis Services Division
Bureau of Epidemiology
Investigation and Studies Division
Surveillance and Statistics Division
Cancer Registry Program
Bureau of Laboratories
Chemical Services Division
Microbiological Services Division
Support Services Division
Bureau of Veterinary Public Health
Zoonosis Control Division
Cooperative Meat Inspection Division
- ASSOCIATE COMMISSIONER FOR SPECIAL HEALTH SERVICES**
Bureau of Long Term Care
Quality Standards Division
Professional Services Division
Bureau of State Health Planning & Resource Development
Bureau of Vital Statistics
Vital Records Division
Statistical Services Division
Bureau of Licensing and Certification
Hospital and Professional Licensure Division
Medicare Certification Division
Pharmacy Division
- ASSOCIATE COMMISSIONER FOR ENVIRONMENTAL AND CONSUMER HEALTH PROTECTION**
Bureau of Radiation Control
Environmental Programs Division
Licensing, Registration and Standards Division
Compliance and Inspection Division
Bureau of Consumer Health Protection
Food and Drugs Division
Milk and Dairy Products Division
Shellfish Sanitation Control Division
Bureau of Solid Waste Management
Permits Division
Surveillance and Enforcement Division
Hazardous Waste and Resource Recovery Programs Management Division
Bureau of Environmental Health
Occupational Health Program
Occupational Safety Division
General Sanitation Division
Water Hygiene Division
- ASSOCIATE COMMISSIONER FOR SUPPORT SERVICES**
Office of Grants and Contract Development
Materials Acquisition and Management Division
Bureau of Automated Data Services
Bureau of Central Administrative Services
Reprographics & Educational Services
Budget and Planning Division
Fiscal Division
General Services Division
- Robert Bernstein, M.D., F.A.C.P. (7378)
Hal L. Nelson, J.D. (7238)
Gary A. Fuchs, B.A. (7484)
Robert A. MacLean, M.D. (7378)
Charles T. Kozel, M.P.H. (7426)
Hermas L. Miller, B.S.A. (7488)
Donald O. Cox, B.S.A. (7364)
Glenn W. Rust, B.S.A. (7301)
C. C. Eaves, M.D. (7770)
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Robert A. Mauck, B.S. (7770)
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Carlos Lozano, D.O.S., M.P.H. (7323)
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Joe B. Horsley (7241)
Bob R. Barnes (7241)
Heien Burt (7445)
Pam Farley (7445)
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Gilbert D. Levine, M.D. (7700)
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Manuel Zapata, B.A. (7336)
Charles H. Gregory, M.D. (7561)
Eugene Weatherall, B.S. (7561)
James Shuffield, B.A. (7401)
Bert Crowson, M.S. (7419)
Jerome H. Greenberg, M.D. (7304)
C. E. Alexander, M.D., Dr.P.H. (7458)
Euel A. Smith, B.A. (7284)
Joe D. Parr (7225)
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Michael J. McCauley, Ph.D. (7570)
F. V. McCasland, D.V.M., M.P.H. (7221)
- James R. Weedon, D.V.M., M.P.H. (7221)
Lynn S. McGuirt, R.N. (7268)
Cesar M. Elzondo, M.D. (7706)
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Maurice B. Shaw, B.S.A., M.S. (7538)
Walter L. Dick, B.S.A. (7531)
Juanita Carroll, Ed.D. (7245)
James O. Allen, R.Ph. (7688)
- David M. Cochran, M.S., P.E. (7541)
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Joseph F. Thiel, B.S. (512/835-7000)
Edgar D. Bailey, M.S., P.E. (512/835-7000)
Richard A. Ratliff, M.S., P.E. (512/835-7000)
Neil B. Travis, B.S., R.S. (Acting) (7537)
Robert L. Hanna, B.S., R.Ph. (7248)
Kimron C. Smith, B.S., R.S. (7281)
Neil B. Travis, B.S., R.S. (7510)
Jack C. Carmichael, M.S., P.E. (7271)
Hector H. Mendietta, B.S.M.E., P.E. (7271)
Llewellyn B. Griffith, Jr., M.S., P.E. (7271)
- Wiley W. Osborne, M.S., P.E. (7271)
C. K. Foster, B.S.C.E., P.E. (7542)
Jerry F. Lauderdale, M.S., P.E. (7254)
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Jess J. Brown, M.Ed. (7211)

Literature

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Section BB

Legislation Impacting a School Health Program

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| Section BB | Legislation Impacting a School Health Program <ul style="list-style-type: none">1.0 Architectural Barriers (Handicapped or Disabled)2.0 Audiometric Use and Registration3.0 Breakfast Programs4.0 Child Abuse, Report of5.0 Communicable Diseases, Rules and Regulations for the Control of6.0 Courses of Study7.0 Employment Contracts, Teachers' (Nurses')8.0 Eye Devices, Protective, in Public Schools9.0 Fire Escapes10.0 Foundation School Program Fund, Requirements for District Participation in the11.0 Handicapped Children, Coordination of Services to12.0 Health Program, Coordinated (Cooperation in Establishment of Program)13.0 Health and Safety14.0 Health Services15.0 Immunization Requirements in Texas, Elementary and Secondary Schools and
Institutions of Higher Education16.0 Immunization; Requirements; Exceptions17.0 Liability, Duties of Professional Employees18.0 Medical Treatment, Consent to19.0 Medication, Administering of by School District Employees; Immunity From Liability20.0 Nurse Practice Act (Registered Nurse)21.0 Open Records Act22.0 Pediculosis, Control and Eradication of in Minors23.0 Physical Evaluations of School Children, Pilot Programs for24.0 Principals, Duties of Public School25.0 Quarantine and Disinfection26.0 Rights, Privileges, and Obligations of 18-Year-Olds27.0 Sanitation and Health Protection28.0 Special Education Program, Comprehensive for Handicapped Children29.0 Student Services30.0 Tuberculosis, Examining Public School Personnel31.0 Tuberculosis, Prevention, Eradication, and Control of32.0 Vision Screening Act of 1979, Children's33.0 Visually Handicapped, Education for the34.0 Vocational Nurse Act35.0 Medical Practice Act of Texas36.0 Texas Pharmacy Act |
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Architectural Barriers (Handicapped or Disabled)

Section BB-1.0

Tex. Rev. Civ. Stat. Ann., Art 601b §§7.01 and 7.04 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§7.01. Policy

The provisions of this article are to further the policy of the State of Texas to encourage and promote the rehabilitation of handicapped or disabled citizens and to eliminate, insofar as possible, unnecessary barriers encountered by aged, handicapped, or disabled persons, whose ability to engage in gainful occupations or to achieve maximum personal independence is needlessly restricted when such persons cannot readily use public buildings.

§7.04. Definitions

For the purpose of this article the following terms have the meanings as herein set forth:

(1) "Nonambulatory disabilities" means impairments that, regardless of cause or manifestation, for all practical purposes, confine individuals to wheelchairs.

(2) "Semiambulatory disabilities" means impairments that cause individuals to walk with difficulty or insecurity.

ty. Individuals using braces or crutches, amputees, arthritics, spastics, and those with pulmonary and cardiac ills may be semiambulatory. The listing here made is illustrative and shall not be construed as being exhaustive.

(3) "Sight disabilities" means total blindness or impairments affecting sight to the extent that the individual functioning in public areas is insecure or exposed to danger.

(4) "Hearing disabilities" means deafness or hearing handicaps that might make an individual insecure in a public area because he is unable to communicate or hear warning signals.

(5) "Disabilities of coordination" means faulty coordination or palsy from brain, spinal, or peripheral nerve injury.

(6) "Aging" means those manifestations of the aging processes that significantly reduce mobility, flexibility, coordination, and perceptiveness but are not accounted for in the aforementioned categories.

Audiometric Use and Registration

Section BB-2.0

Tex. Rev. Civ. Stat. Ann., Art. 4590F, §10b (Vernon Supp. 1982). 25 Tex. Admin. Code §289.3 (McGraw-Hill, 1981).

The Texas State Radiation Control Agency may institute training programs for the purpose of qualifying personnel to carry out the provisions of this Act, and may make said personnel available for participation in any program or programs of the Federal Government, other states or interstate agencies in furtherance of the purposes of this Act.

§130.1. Purpose

The purpose of this part is to provide for the registration of possession and use of audiometers, audiometric testing devices, and audiometric calibration equipment.

§130.2. Scope

All audiometers, audiometric testing devices, or audiometric calibration equipment unless exempt from this part by paragraphs 130.3 or 130.4 shall be registered with the Agency (Texas Department of Health) in accordance

with the requirements of paragraph 130.5. Each user of an audiometer or audiometric testing device shall be registered with, trained by, or have training approved by, and shall file reports as directed by the Agency. Persons calibrating audiometers, audiometric testing devices, or audiometric calibration equipment shall be registered with, have training approved by, and shall file reports as directed by the Agency.

§130.5. Registration

(a) Each person having possession of, or using audiometers, audiometric testing devices, or audiometric calibration equipment not exempted by these regulations, shall register such equipment within thirty (30) days following the commencement of an activity involving the operation of an audiometer, audiometric testing device, or audiometric calibration equipment.

Breakfast Programs

Section BB-3.0

Tex. Educ. Code Ann., §21.914 (Vernon Supp. 1982). See *Texas School Law Bulletin 1982*, TEA Pub. AD1 013 01.

§21.914.

If at least 10 percent of the students enrolled in one or more schools in a school district are eligible for free or reduced-price breakfasts under the national school breakfast program provided for by the Child Nutrition Act

of 1966 (42 U.S.C. Subsection 1773), the governing board of the district shall participate in the program and make the benefits of the program available to all eligible students in said schools.

Report of Child Abuse

Section BB-4.0

Tex. Fam. Code Ann., §§34.01, 34.03, 34.04, 34.06 (Vernon 1975). *Tex. Fam. Code Ann.* §§34.011, 34.02, 34.05, 34.07, 34.08 (Vernon Supp. 1982). See *Texas School Law Bulletin 1982*, TEA Pub. AD1 013 01.

§34.01. Persons Required to Report

Any person having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect shall report in accordance with Section 34.02 of this code.

§34.011. Form

The Texas Department of Human Resources shall promulgate a form and cause a sample to be distributed for the reporting of suspected occurrences of child abuse as required by Section 34.01 of this code. Copies of the form shall be distributed to all licensed hospitals in this state to be available for use without charge by hospital employees, physicians, patients, and other persons. The form shall include a statement that child abuse reports are confidential and that information contained in the reports, including the name of the person making the report, may be used only for the purposes consistent with the investigation of child abuse. The form shall give the address of the Texas Department of Human Resources. Hospital employees, physicians, patients, and other persons must complete the form and return it to the Texas Department of Human Resources.

§34.02. Contents of Report: to Whom Made

(a) Nonaccusatory reports reflecting the reporter's belief that a child has been or will be abused or neglected, or has died of abuse or neglect, has violated the compulsory school attendance laws on three or more occasions, or has, on three or more occasions, been voluntarily absent from his home without the consent of his parent or guardian for a substantial length of time or without the intent to return shall be made to:

- (1) the State Department of Public Welfare;
- (2) the agency designated by the court to be responsible for the protection of children; or
- (3) any local or state law enforcement agency.

(b) All reports must contain the name and address of the child, the name and address of the person responsible for the care of the child, if available, and any other pertinent information.

(c) All reports received by any local or state law enforcement agency shall be referred to the State Department of Public Welfare or to the agency designated by the court to be responsible for the protection of children.

(d) An oral report shall be made immediately on learning of the abuse or neglect as prescribed in Subsection (a) of this section, and a written report shall be made within five days to the same agency or department. Anonymous reports, while not encouraged, will be received and acted on in the same manner as acknowledged reports.

§34.03. Immunities

Any person reporting pursuant to this chapter is immune from liability, civil or criminal, that might otherwise be incurred or imposed. Immunity extends to participation in any judicial proceeding resulting from the report. Persons reporting in bad faith or malice are not protected by this section.

§34.04. Privileged Communications

In any proceeding regarding the abuse or neglect of a child or the cause of any abuse or neglect, evidence may not be excluded on the ground of privileged communication except in the case of communications between attorney and client.

§34.05. Investigation and Report of Receiving Agency

(a) The State Department of Public Welfare or the agency designated by the court to be responsible for the protection of children shall make a thorough investigation

promptly after receiving either the oral or written report. The primary purpose of the investigation shall be the protection of the child.

(b) In the investigation the department or agency shall determine:

- (1) the nature, extent, and cause of the abuse or neglect;
- (2) the identity of the person responsible for the abuse or neglect;
- (3) the names and conditions of the other children in the home;
- (4) an evaluation of the parents or persons responsible for the care of the child;
- (5) the adequacy of the home environment;
- (6) the relationship of the child to the parents or persons responsible for the care of the child;
- (7) all other pertinent data.

(c) The investigation shall include a visit to the child's home, a physical examination of all the children in that home, and an interview with the subject child. The investigation may include a psychological or psychiatric examination of all the children in that home. If admission to the home, school, or any place where the child may be, or permission of the parents or persons responsible for the child's care for the physical examinations cannot be obtained, then the juvenile court, or the district court, upon cause shown, shall order the parents or the persons responsible for the care of the children, or the person in charge of any place where the child may be, to allow entrance for the interview, the physical examination, and the investigation. If the parents or person responsible for the child's care does not consent to a psychological or psychiatric examination of the child that is requested by the department or agency, the juvenile court or district court, upon cause shown, shall order the examination to be made at the times and places designated by the court. A parent or person responsible for the child's care is entitled to notice and a hearing when the department or agency seeks a court order to allow a psychological or psychiatric examination.

(d) If, before the investigation is complete, the opinion of the investigators is that immediate removal is necessary to protect the child from further abuse or neglect, the investigators shall file a petition pursuant to Chapter

17 of this code¹ for temporary care and protection of the child.

(e) The agency designated by the court to be responsible for the protection of children or the department shall make a complete written report of the investigation. The report, together with its recommendations, shall be submitted to the juvenile court or the district court, the district attorney, and the appropriate law enforcement agency if sufficient grounds for the institution of a suit affecting the parent-child relationship are found.

(f) On the receipt of the report and recommendation required by Subsection (e) of this section, the court may direct the investigator to file a petition seeking appropriate relief under Subtitle A of this title.²

¹Section 17.01 et seq.

²Section 11.01 et seq.

§34.06. Central Registry

The State Department of Public Welfare shall establish and maintain in Austin, Texas, a central registry of reported cases of child abuse or neglect. The department may adopt rules and regulations as are necessary in carrying out the provisions of this section. The rules shall provide for cooperation with local child service agencies, including hospitals, clinics, and schools, and cooperation with other states in exchanging reports to effect a national registration system.

§34.07. Failure to Report; Penalty

(a) A person commits an offense if the person has cause to believe that a child's physical or mental health or welfare has been or may be further adversely affected by abuse or neglect and knowingly fails to report in accordance with Section 34.02 of this code.

(b) An offense under this section is a Class B misdemeanor.

§34.08. Confidentiality

The reports, records, and working papers used or developed in an investigation made under this chapter are confidential and may be disclosed only for purposes consistent with the purposes of this code under regulations adopted by the investigating agency.

Rules and Regulations for the Control of Communicable Diseases Section BB-5.0

25 *Tex. Admin. Code* §§97.1-97.9 (McGraw-Hill, 1981).

§97.1. Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Carrier—A person who harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source or reservoir of infection for man.

Case—As distinct from a carrier, the term "case" is used to mean a person in whose tissues the etiological agent of a communicable disease is lodged and which usually produces signs or symptoms of disease. Evidence of the presence of a communicable disease may be also revealed by routine laboratory findings.

Communicable disease—An illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a well person from an infected person or animal, or through the agency of an intermediate animal host, vector, or inanimate object in the environment.

Contact—A person or animal that has been in such association with an infected person or a contaminated environment so as to have had opportunity to acquire the infection.

Disinfection—Killing of pathogenic agents outside the body by chemical or physical means directly applied.

Epidemic or outbreak—An epidemic or outbreak is here defined as the occurrence in a community or region of a group of illnesses of similar nature, clearly in excess of normal expectancy, and derived from a common or a propagated source.

Infectious disease—A disease of a man or animal resulting from the entry and development or multiplication of a particular pathogen in the body of man or animal.

Isolation—The separation for the period of communicability of infected individuals from other individuals, in such places and under such conditions as will prevent the direct or indirect transmission of the infectious agent from infected individuals to other individuals who are susceptible or who may spread the agent to others.

Local health authority—For the purpose of these sections the term "local health authority" shall be held to designate the city or county health officer, a director of an organized health department or a local board of health, or the director of a Texas Public Health Region, within their respective jurisdictions.

Modified quarantine—As authorized by the commissioner of health, measures established by the local health authority which are carried out as necessary to protect the public health.

Quarantine—The limitation of freedom of movement of such well persons or domestic animals as have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period.

Report of a disease—By report of a disease or outbreak of disease cases is meant the notification to the local health authority of each and all disease cases including all information required by the procedures established by the commissioner of health.

Reportable disease—A "reportable disease" shall mean any disease or condition for which an official report is required.

See §97.5(b) of this title (relating to Prevention of the Spread of Disease from a case). Any unusual group ex-

pression of illness which may be of public concern is reportable and shall be reported to the local health authority or the Texas Department of Health by the most expeditious means.

§97.2. Diseases Requiring Exclusion from School

(a) Children suffering from any reportable disease shall be barred from school attendance.

(b) In addition to reportable diseases, children suffering from scabies, impetigo contagiosa, ringworm, trachoma, common cold, infectious forms of conjunctivitis, and pediculosis also may be barred from school attendance.

(c) All children excluded from school for reason of communicable disease may be readmitted to school by one of the following methods:

(1) On the certificate of the attending physician attesting to their recovery and non-infectiousness.

(2) A permit for readmission to school issued by a local health authority. See §97.1 of this title (relating to Definitions).

(3) After a period of time corresponding to the communicability of the disease as established by the commissioner of health. The method of readmission to school is to be determined by the local health authority in each particular area.

§97.3. Hospitals to Report Communicable Diseases

(a) The chief administrative officer of each civilian hospital, dispensary, or clinic in the State is requested to appoint an individual from the full time staff, hereinafter referred to as the "reporting officer," who shall be responsible for reporting to the local health authority cases or suspect cases of communicable diseases admitted to the facility. The United States military and other federally operated hospitals and clinics are requested to do likewise.

(b) Hospital and clinic reports shall be made to the local health authority at weekly intervals.

(c) Reporting officers shall telephone immediately reports of cases or suspect cases as delineated on the official list of reportable diseases. See §97.5(b) of this title (relating to Prevention of the Spread of Disease from a Case).

(d) Reports of communicable diseases shall be based on all patients having presumptive or confirmed diagnosis of a disease as prescribed in §97.5(b) of this title (relating to Prevention of the Spread of Disease from a Case) who, during the reported week:

(1) were newly admitted to a facility, including emergency room;

(2) were admitted to an isolation unit;

(3) were discharged, disease not previously reported;

(4) died, disease not previously reported; or,

(5) were evaluated in an out-patient unit.

(e) Official reports of preliminary nature shall be held by the local health authority until a final diagnosis has been made.

(f) Reporting of a case of communicable disease by a hospital shall be in addition to, and not as a substitute for, the reporting required of the attending physician or other persons having knowledge of the case.

§97.4. Physicians to Report Diseases

(a) It is hereby made the duty of every physician holding a license to practice medicine in the State of Texas to report to the local health authority, immediately after his or her first professional visit, each patient he or she shall examine and who has or is suspected of having any reportable disease, as prescribed in §97.1 of this title (relating to Definitions), and to report any recognized outbreak of illness of any kind whether or not the disease is known to be communicable or reportable. A physician may authorize a member of his staff to transmit reports. The local health authority shall collect the reports and transmit the information at weekly intervals to the Texas Department of Health in a manner prescribed by the commissioner of health. Known or suspected cases of botulism, cholera, diphtheria, plague, louse-born relapsing fever, paralytic poliomyelitis, smallpox, epidemic typhus, and yellow fever are to be reported immediately and directly to the Texas Department of Health as well as to the local health authority. When a case or outbreak of communicable disease is reported to a local health authority, and the person or persons diagnosed as having the disease reside outside his area of local health jurisdiction, the local health authority receiving the report shall notify the appropriate local health authority where the person or persons reside. He shall also notify the local health authority of any other area where, in his opinion, transmission of the disease may have occurred. The Texas Department of Health shall assist the local health authority in providing such notifications if requested. The local health authority of the area where the case or outbreak is diagnosed shall report the case or outbreak to the Texas Department of Health on the same basis as other reports.

(b) The local school authorities shall report to the local health authority those children attending school who are suspected of having a reportable disease. Procedures for determining which children should be so suspected and reported, and for their exclusion from school pending appropriate medical diagnosis or recovery, shall be defined by the local health authority according to policies established by the commissioner of health.

(c) When a physician is not in attendance, or when a case of a reportable disease has for any reason not been reported, it shall be the duty of every professional registered nurse; every medical laboratory director; every military installation, military or other federally-operated hospital, clinic, jail or detention center; every superintendent, principal, teacher, school health official, or counselor of a public or private school; every administrator or health official of

a public or private institution of higher learning; every owner or manager of a restaurant, dairy, or other food-handling or food-processing establishment or food outlet; every superintendent, manager, or health official of a public or private camp, home, or institution; every parent, guardian, or householder; every professional health worker or other person having knowledge of any person affected with any disease apparently or presumably communicable to notify at once the local health authority or the Texas Department of Health of all facts in relation to the illness and physical condition of any such person.

§97.5. Prevention of the Spread of Disease from a Case.

(a) *General.* It shall be the duty of the local health authority upon identification of a case or upon receipt of notification or report of such diseases to take such action and measures as may be necessary according to any policies which may be established by the commissioner of health, within the provisions of these rules and regulations, to prevent the spread of any communicable disease to other people.

(b) *List of reportable diseases.* There will be publicly declared by the Texas Board of Health, from time to time as is expedient and as necessity requires and the public health demands, a list of diseases to be reportable and, when any disease is so declared to be a reportable disease, the regulations herein provided shall apply to all listed diseases as if each had been specifically listed as reportable herein. The information required to be reported for each disease will be specified in the list. (The organization of diseases into categories for immediate reportings, weekly reporting, reporting by numeric totals vs. name, address, age, sex, race, etc., is all accomplished by the list.)

(c) Notification of school authorities.

(1) Whenever any local health authority is notified of the existence of any communicable disease in any household, it shall be his duty to notify officially the appropriate county or city superintendent of schools, or the principal of any school not under the jurisdiction of the city or county board of education and patronized by a member or members of the infected household. The local health authority shall prohibit the attendance of any person from the infected household at any public or private school when and for such a period of time as, in his opinion, there is danger of such persons transmitting infection.

(2) Whenever a local health authority notifies the county or city superintendent of schools or the principal of any school not under the jurisdiction of a city or county board of education of the existence of disease in a communicable stage in any household sending children to public or private schools within his jurisdiction, he shall notify the principal or teacher of said school to refuse admission to any pupil residing in such infected household until such pupil or pupils shall comply with readmission

procedures as stated in Section §97.2(c) of this title (relating to Diseases Requiring Exclusion from School).

(3) Parents, guardians, and others in charge of any household wherein exists any diseases in a communicable stage shall not allow any child or other person residing therein to attend any private or public school until readmitted as stated in Section §97.2(c) of this title (relating to Diseases Requiring Exclusion from School).

(d) *Closure of school and places of public or private assembly.* The local health authority is empowered to close any public or private school or other place of public or private assembly when in his opinion such closing is necessary to protect the public health; and such school or other place of public or private assembly shall not reopen until permitted by the health authority who caused its closure.

§97.6. Quarantine of Diseases, Persons, and of Contacts within Specific Premises

The local health authority is hereby empowered and it is made his duty that whenever a case of communicable disease occurs in any household or place within his jurisdiction, and it is in his opinion necessary or advisable in order to protect the public health that persons residing therein shall be kept from contact with the public, to declare the house, building, apartment, room, or place wherein the case occurs to be a place of quarantine, and to require that no person shall leave or enter said quarantine place during the period of quarantine except with specific permission of the health authority who declared such quarantine.

§97.7. General Control Measures for Reportable Diseases

Except for diseases for which equivalent measures of investigation and control are specifically provided in other sections of these regulations, it shall be the duty of the local health authority or his duly authorized representative to proceed as follows:

(1) Investigation shall be made as the circumstances may require for the purpose of verification of the diagnosis, ascertaining the source of the causative agent, disclosing unreported cases, and revealing contacts.

(2) Laboratory specimens of the body tissues, fluids, or discharges, and of materials directly or indirectly associated with the case, as may be necessary or desirable in confirmation of the diagnosis or for ascertaining the source of the infection, shall be collected and submitted to a laboratory for examination.

(3) Control techniques, including disinfection, environmental sanitation, artificial immunizations, and other recognized measures, shall be instituted as may be necessary to reduce morbidity and mortality. In establishing quarantine or isolation, the local health authority shall designate and define the limits of the areas in which the persons are quarantined or isolated.

(4) Information concerning the disease and its prevention shall be given to the patient or a responsible member of his household to prevent further spread of said disease.

(5) Control measures implemented by the local health authorities shall be at least as stringent as those established by the commissioner of health and shall be subject to review and alteration by the commissioner of health.

§97.8. Specific Control Measures for Certain Reportable Diseases

(a) The local health authority shall place cases of infectious diseases in isolation as may be necessary for protection of the public health. The commissioner of health shall provide sufficient guidance to recommend appropriate infectious disease control measures for institution by all local health authorities.

(b) The following diseases are subject to international quarantine and special isolation procedures may be necessary:

(1) *Cholera.*

(A) *Isolation.* Special isolation of patient beyond routine hospitalization is not necessary.

(B) *Quarantine.* The patient may not be released from the hospital except under special orders from the commissioner of health.

(2) *Plague (bubonic or pneumonic).*

(A) *Isolation.* Hospitalize all patients if practical; take reasonable aseptic precautions for patients with bubonic plague, and require strict isolation for primary pneumonic plague or for any patient developing pneumonic plague.

(B) *Quarantine.* Contacts of pneumonic plague must be quarantined for 6 days with close surveillance for developing illness; contacts and their clothing must be freed of arthropod vectors.

(C) *Disinfection.* Persons at risk of being bitten by infected fleas shall be protected by procedures to kill fleas, according to recommendations which may be established by the commissioner of health.

(3) *Smallpox.*

(A) *Isolation.* Isolation in screened wards or rooms until all scabs and crusts have disappeared.

(B) *Quarantine.* All persons living or working on the same premises as or otherwise having intensive exposure to the person who develops smallpox, shall be considered contacts, and promptly vaccinated or revaccinated, or quarantined for 16 days from last exposure. If such contacts are considered immune by reason of prior attack or successful revaccination within the previous three years, they shall be kept under surveillance until the height of the reaction to the recent vaccination has passed. If the contact is not considered immune, he shall be kept under surveillance until 16 days have passed since the last contact. Any rise in temperature during surveillance calls for prompt isolation until smallpox is excluded.

(4) *Yellow Fever.*

(A) *Isolation.* None: Prevent access of mosquitoes to patient during first three days by using screened sickroom or by spraying quarters with insecticide having residual effect.

(B) *Quarantine.* None.

(5) *Diphtheria.*

(A) *Isolation.* Until two sets of throat cultures from nose and throat taken not less than 24 hours apart and not less than 24 hours after cessation of antimicrobial therapy fail to show diphtheria bacilli. Where culture is impractical, isolation may be ended after 14 days following onset of disease.

(B) *Concurrent disinfection.* All articles in contact with patient and all articles soiled by discharges of patient shall be disinfected.

(C) *Quarantine.* All intimate contacts shall be placed under modified quarantine until nose and throat cultures are negative. All carriers shall be treated with appropriate antimicrobial therapy, as if they were cases. Adult contacts whose occupation involves either handling of food or close association with children must be excluded from those occupations until bacteriologic examination proves them not to be carriers.

(D) *Immunization of contacts.* Contacts intimately exposed and not previously immunized with toxoid shall be given the first dose of toxoid and an appropriate antibiotic if culture is positive or shall be placed under appropriate quarantine measures for a period of seven days, or both. Both children and adults will be examined daily by a physician for no less than seven days and provided with such further immunization as may be necessary to confer full protection. Contacts previously immunized with toxoid shall have a booster dose of toxoid or shall be placed under appropriate quarantine measures for a period of seven days or both.

(E) *Investigation of contacts.* Unreported cases, carriers, and atypical cases among intimate contacts will be identified, reported, and treated as in the foregoing provisions.

(6) *Tuberculosis.*

In all cases of infectious tuberculosis, the local health authority may isolate the case until it is either non-

infectious or in his opinion no longer dangerous to the contacts (refer Texas Civil Statutes, article 4477-11).

(7) *Paralytic poliomyelitis.*

(A) *Isolation.* Patients shall be hospitalized. Contact with unimmunized hospital staff and others shall not be permitted for seven days.

(B) *Disinfection.* Throat discharges and feces and articles soiled therewith shall be discharged directly into toilets attached to sanitary sewers or be disinfected by means approved by the commissioner of health.

(C) *Contacts.* All non-immune persons known to be exposed to paralytic poliomyelitis shall submit to quarantine ordered by the local health authority in order that early symptoms of new cases may be detected and that spread may be prevented.

(D) *Prevention.* The commissioner of health in coordination with appropriate local health authority may order immunization with vaccines and/or quarantine for susceptibles exposed to an infectious case of paralytic poliomyelitis for a period of no more than 21 days following exposure to an infectious individual.

(8) *Animal rabies.*

Rules and regulations for the prevention and control of animal rabies are promulgated in compliance with Texas Civil Statutes, article 4477-6a.

(c) Declaration of the existence of an epidemic: The local health authority or the commissioner of health may declare the existence of an outbreak or epidemic of any disease, identified or unidentified, occurring within the approximate confines of any locality.

§97.9. Confidential Nature of Case Reporting

(a) All individual morbidity case reports received by the local health authority or the Texas Department of Health are to be considered confidential records and not public records.

(b) Health records, public and private are subject to confidential review by the delegated agent of the local health authority and/or the commissioner of health who shall determine that review of those records is necessary for the protection of the public health may be provided to the Texas Department of Health as provided by law.

Courses of Study

Section BB-6.0

Tex. Educ. Code Ann., §21.101 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.101. Required Curriculum

(a) Each school district that offers kindergarten through grade 12 shall offer a well-balanced curriculum that includes:

(1) English language arts;

(2) other languages, to the extent possible;

(3) mathematics;

(4) science;

(5) health;

(6) physical education;

- (7) fine arts;
- (8) social studies;
- (9) economics, with emphasis on the free enterprise system and its benefits;
- (10) business education;
- (11) vocational education; and
- (12) Texas and United States history as individual subjects and in reading courses.

(b) The State Board of Education by rule shall designate subjects comprising a well-balanced curriculum to be offered by a school district that does not offer kindergarten through grade 12.

(c) The State Board of Education by rule shall designate the essential elements of each subject listed in Subsection (a) of this section and shall require each district to provide instruction in those elements at appropriate grade levels. In order to be accredited, a district must provide instruction in those essential elements as specified by the state board.

(d) Local instructional plans may draw upon state curriculum frameworks and program standards as appropriate. The responsibility for enabling all children to participate actively in a balanced curriculum which is designed to meet individual needs rests with the local school district. Districts are encouraged to exceed minimum requirements of the law. A primary purpose of the public

school curriculum in Texas shall be to prepare thoughtful, active citizens who understand the importance of patriotism and can function productively in a free enterprise society with appreciation for the basic democratic values of our state and national heritage.

(e) The State Board of Education shall provide for optional subjects in addition to those provided by Subsection (a) of this section as appropriate for districts that require choices in order to address unique local needs. In addition, the commissioner of education may permit a school district to vary from the required curriculum as necessary to avoid hardship to the district.

(f) Not later than the 30th day preceding the day on which each regular session of the legislature convenes, the State Board of Education shall transmit to the governor, the lieutenant governor, and the legislature a report on the status of curriculum in the public schools. The report shall include recommendations for legislative changes necessary to improve, modify, or add to the curriculum.

(g) The State Board of Education and local school districts shall foster the continuation of the tradition of teaching American and Texas history and the free enterprise system in regular subject matter and in reading courses in the public free schools of Texas and in the adoption of textbooks.

Teachers' (Nurses') Employment Contracts

Section BB-7.0

Tex. Educ. Code Ann., §§21.201-21.211 (Vernon Supp. 1982). See Texas School Law Bulletin 1992, TEA Pub. AD1 013 01.

§21.201. Definitions

As used in this subchapter, the following terms shall have the meaning ascribed to them in this section.

(1) "Teacher" means a superintendent, principal, supervisor, classroom teacher, counselor, or other full-time professional employee, except paraprofessional personnel, who is required to hold a valid certificate or teaching permit.

(2) "Board" and "board of trustees" means the governing board of a public school district.

(3) "School district" means any public school district in this state.

(4) "Term contract" means any contract of employment for a fixed term between the school district and a teacher.

§21.202. Teacher Evaluations

The board of trustees of each school district shall provide by written policy for the periodic written evaluation of each teacher in its employ at annual or more frequent intervals. Such evaluation shall be considered by the board of trustees prior to any decision by the board not to renew the term contract of any teacher.

§21.203. Nonrenewal of Term Contracts

(a) The board of trustees of each school district may choose not to renew the employment of any teacher employed under a term contract effective at the end of the contract period.

(b) The board of trustees of each school district shall establish policies consistent with this subchapter which shall establish reasons for nonrenewal.

(c) The board of trustees of each school district shall establish policies and procedures for receiving recommendations from its school administration for the nonrenewal of teacher term contracts, excepting only the general superintendent of schools.

§21.204. Notice

(a) In the event the board of trustees receives a recommendation for nonrenewal, the board, after consideration of the written evaluations required by Section 21.202 of this subchapter and the reasons for the recommendation, shall, in its sole discretion, either reject the recommendation or shall give the teacher written notice of the proposed nonrenewal on or before April 1 preceding the end of the employment term fixed in the contract.

(b) In the event of failure to give such notice of proposed nonrenewal within the time herein specified, the board of trustees shall thereby elect to employ such employee in the same professional capacity for the succeeding school year.

(c) The notice of proposed nonrenewal required in this section shall contain a statement of all the reasons for such proposed action.

§21.205. Hearing

(a) If the teacher desires a hearing after receiving notice of the proposed nonrenewal, the teacher shall notify the board of trustees in writing within 10 days after receiving the notice of nonrenewal. The board shall provide for a hearing to be held within 15 days after receiving written notice from the teacher requesting a hearing. Such hearing shall be closed unless an open hearing is requested by the employee.

(b) The hearing shall be conducted in accordance with rules promulgated by the district.

§21.206. Decision of Board

(a) If the teacher fails to request a hearing, the board shall take such action as it deems lawful and appropriate and shall notify the employee in writing of that action within 15 days of the expiration of the 10-day period for requesting a hearing.

(b) If the teacher requests a hearing, the board shall take such action as it deems lawful and appropriate and shall notify the teacher in writing of that action within 15 days following the conclusion of the hearing.

§21.207. Appeal

(a) If the teacher is aggrieved by the decision of the board of trustees, he may appeal to the State Commissioner

of Education pursuant to Section 11.13 of this code. The commissioner may not substitute his judgment for that of the board of trustees, unless the decision below was arbitrary, capricious, unlawful, or not supported by substantial evidence.

(b) The State Board of Education shall have jurisdiction to hear appeals from such decisions of the State Commissioner of Education.

§21.208. Superintendents

If a majority of the board of trustees of any school district shall determine that the term contract of the general superintendent of school should be considered for nonrenewal, the provisions of this subchapter shall apply, except that there need not be a recommendation from the designated school administration.

§21.209. Probation

The board of trustees of any school district may provide by written policy for a probationary period not to exceed the first two years of continuous employment in the district, in which case the provisions of this subchapter shall not apply during such probationary period.

§21.210. Discharge for Cause

Nothing in this subchapter shall prohibit a board of trustees from discharging a teacher for cause during the term of the contract.

§21.211. Exemptions

This subchapter does not apply to teachers who are employed under the provisions of the probationary or continuing contract law as set out in Subchapter C of Chapter 13 of this code.

Protective Eye Devices in Public Schools

Section BB-8.0

Tex. Educ. Code Ann., §21.909 (Vernon Supp. 1975). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.909.

(a) Industrial quality eye-protective devices shall be worn by every teacher and pupil in Texas participating in any of the following courses:

(1) vocational or industrial arts shops or laboratories involving experience with:

- (A) hot molten metals;
- (B) milling, sawing, turning, shaping, cutting or stamping of any solid materials;
- (C) heat treatment, tempering, or kiln firing of any metal or other materials;
- (D) gas or electric arc welding; or
- (E) caustic or explosive materials; or

(2) chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids.

(b) In this section, "industrial quality eye-protective devices" means devices meeting the standards set by the State Department of Health.

(c) The governing boards and administrators of Texas school districts offering any of the listed courses are responsible for furnishing free of charge or providing at cost to teachers and pupils participating in the courses the required eye-protective devices.

(d) Whenever an accident occurs during the conduct of any of the courses described in Subsection (a) of this

section, and an injury to the eye of a teacher or pupil results, the principal shall make a full written report of the accident and injury to the State Department of Education.

The department shall prescribe the form and content of the reports and shall maintain a file of all reports submitted.

Fire Escapes

Section BB-9.0

Tex. Rev. Civ. Stat. Ann., Arts. 3955, 3959 (Vernon Supp. 1966). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

Art. 3955. Owner to Provide

The owner of each building, which is or may be constructed within this State, three or more stories in height or in case of schoolhouses two or more stories in height, constructed, used, or intended to be used in whole or in part as any of the following buildings, shall provide and equip such buildings with at least one adequate fire escape, and such additional fire escapes, as provided in the three succeeding Articles.

Art. 3959. State, County, City and School Buildings [Sec. A omitted]

B. Each school building which is or may be constructed within this State of two (2) or more stories in height, which is owned by any school district, and in which schools of any kind are conducted, shall be provided and equipped with an adequate fire escape or fire escapes to the extent and in accordance with requirements as follows:

Definitions

The following terms, words, and phrases as used in subdivision B of this Article shall have the following meanings unless a different meaning is plainly required by the context:

a. "Story" means the space included between two (2) successive floor levels except that a basement shall be construed as a story only when the floor level immediately above the basement is ten (10) feet or more above grade line on one or more sides of the building.

b. Types of construction shall be, for purpose of application of this law, classified as follows: "Fireproof," "semi-fireproofed," and "ordinary" as defined in the latest edition of the Building Code Recommended by the National Board of Fire Underwriters.

Number and Types of Fire Escapes Required

a. Any school building three (3) stories or more in height of "fireproof construction," "semi-fireproof construction," or "ordinary construction" shall have one fire escape for every two hundred and fifty (250) pupils or major fraction thereof housed in the building above the first floor.

b. Any school building two (2) stories in height of "ordinary" construction shall have one fire escape for every two hundred and fifty (250) pupils housed above the first floor, or major fraction thereof.

c. Fire escapes for school buildings heretofore constructed may be either of the interior type, specifications for which are now provided in Article 3966, Title 63, Revised Civil Statutes, 1925, or exterior type as in this amendment hereinafter described. Exterior type fire escapes shall be free from obstruction, shall be constructed so as to secure a safe exit for children, shall be conveniently accessible from each floor above first, and shall be of sufficient width and strength so that each step and landing may accommodate two (2) adult persons at the same time. The exits from each floor shall consist of doorways, the base of which shall be at the same level as the corresponding floor of such building and the landing of the fire escape to which it leads, provided the State Department of Education approves such to be a convenient and safe passage. Each such doorway shall be not less than three (3) feet wide nor less than six (6) feet six (6) inches high, and shall be fitted with panic hardware approved by the National Board of Fire Underwriters. If there shall be two (2) or more rooms or hallways, or room and hallway, adjoining and convenient to the landing of a fire escape, each such room or hallway shall have a doorway leading to such landing.

d. Fire escapes for new school building of three (3) stories or more in height, of "fireproof" construction, shall be interior, specifications for which are now provided in Article 3966, Title 63, Revised Civil Statutes, 1925.

New school buildings hereinafter constructed and existing school buildings heretofore constructed of two (2) stories and less in height, of "fireproof" or "semi-proof" construction, or having stairways and hallways of either of these types shall not be required to have fire escapes.

New school buildings hereinafter constructed of two (2) stories or more in height of "ordinary" construction shall have interior types of fire escapes, specifications for which are now provided in Article 3966, Title 63, Revised Civil Statutes, 1925.

Description of Fire Escapes

a. Exterior fire escapes for the purpose of subdivision B of this amended Article shall be of the following construction, or similar ones approved by the National Board of Fire Underwriters.

(1) They shall be of incombustible materials throughout.

(2) They shall be designed for a live load of one hundred (100) pounds per square foot. The calculated live load

shall be clearly stated on the plans submitted for approval.

(3) As a rule, fire escapes shall be supported by vertical steel columns. Where such construction is not possible because of conditions the use of steel brackets with bolts extending through the entire thickness of the wall may be approved.

(4) Landings and treads shall be of solid hatched steel plate or of steel gratings with interstices not exceeding three-fourths ($\frac{3}{4}$) inches and so designed that the accumulation of snow and ice will be reduced to a minimum.

(5) Guard rails shall be at least three (3) feet six (6) inches in height and shall be substantially constructed. They shall be faced with heavy wire mesh, or steel balusters or rails not more than nine and one-half ($9\frac{1}{2}$) inches o.c. may be used.

(6) There shall be handrails on each side of the stairs, securely attached to the guard rails or to the building walls. Handrails shall be two (2) feet four (4) inches to two (2) feet six (6) inches above the nosings.

(7) On present existing structures exterior type fire escapes, for the purpose of subdivision B of this amended Article, shall be an iron, steel or concrete stairway type fire escape, or an iron or steel straight chute type fire escape, or an iron or steel spiral chute type fire escape, or a combination of said three (3) types of fire escapes.

(8) Exterior type fire escapes, for the purpose of subdivision B of this amended Article, may be an iron or steel straight chute type fire escape or an iron or steel spiral chute type fire escape.

b. Design of interior fire escapes in addition to the

specifications set out in Article 3966, Title 63, Revised Civil Statutes, 1925, shall be as follows:

(1) Stairs and landings shall be not less than three (3) feet six (6) inches long and not less than three (3) feet wide.

(2) Treads shall be not less than nine (9) inches wide plus a nosing of one (1) inch. Risers shall be not more than seven and one-fourth ($7\frac{1}{4}$) inches.

(3) There shall be not more than a nine (9) foot six (6) inch rise in a single run. Longer runs shall be interrupted by landings at least as deep as the width of the stairs.

(4) Stairs shall extend continuously to the ground. Counter-balanced and swinging sections will not be approved.

c. Exits of exterior fire escapes shall be as follows:

(1) Doors leading to fire escapes shall open on landings at least the width of the doors.

(2) Exit doors shall swing outward, shall be at least three (3) feet no inches by six (6) feet six (6) inches, shall be glazed with wire glass, and shall have their bottoms level with the floors of the rooms or corridors and landings they serve. Windows are prohibited as means of access to fire escapes.

(3) Exit doors shall be secure only by panic hardware approved by the National Board of Fire Underwriters. Hooks, latches, bolts, locks, etc. are prohibited.

d. Windows located beneath or within ten (10) feet in any direction of fire escapes shall be glazed with wire glass.

Requirements for District Participation in the Foundation School Program Fund

Section BB-10.0

Tex. Educ. Code Ann., Chapter 16, Subchapter B, §§16.051-16.055 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§16.051. Required Compliance

In order to receive financial support from the Foundation School Fund, a school district must comply with the standards set forth in this subchapter.

§16.052. Operation of Schools

(a) Each school district must provide for not less than 175 days of instruction for students and not less than 10 days of inservice training and preparation for teachers for the 1977-78 school year and not less than 175 days of instruction for students and not less than eight days of inservice training and preparation for teachers for each school year thereafter, except as provided in Subsection (b) of this section.

(b) The commissioner of education may approve the operation of schools for less than the number of days of instruction and inservice training and preparation otherwise required when disasters, floods, extreme weather con-

ditions, fuel curtailments, or other calamities have caused the closing of the school.

§16.053. Accreditation

Beginning with the 1977-1978 school year each school district must be accredited by the Central Education Agency.

§16.054. Student/Teacher Ratios

Each school district must employ a sufficient number of certified teachers to maintain an average ratio of not less than one teacher for each 25 students in average daily attendance.

§16.055. Compensation of Professional and Para-professional Personnel

(a) A school district must pay each employee who is qualified for and employed in a position classified under

the Texas Public Education Compensation Plan set forth in Section 16.056 of this chapter not less than the minimum monthly base salary, plus increments for teaching experience, specified for the position.

(b) Contracts for personnel shall be made on the basis of a minimum of 10 months' service, which must include the number of days of instruction for students and days of inservice training and preparation for personnel required by Section 16.052 of this code. The days of inservice training and preparation required herein shall be conducted by local boards of education under rules and regulations established by the State Board of Education that are consistent with the state accreditation standards for program planning, preparation, and improvement. Personnel

employed for more than 10 months shall be paid not less than the minimum monthly base pay plus increments for experience for each month of actual employment. Personnel employed for 11 months at pay grades 1-11 must render 202 days of service, and personnel employed for 12 months at pay grades 1-11 must render 220 days of service. Personnel employed for 11 months at pay grades 12-18 must render 207 days of service, and personnel employed for 12 months at pay grades 12-18 must render 226 days of service. However, the number of days of service required by this subsection may be reduced by the commissioner under Section 16.052(b) of this code, and the reduction shall not reduce the total salaries of personnel.

Coordination of Services to Handicapped Children Section BB-11.0

Tex. Educ. Code Ann., §11.103 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§11.103.

(a) In this section "handicapped children" has the meaning defined in Section 16.104(b) of this code.

(b) The commissioner of education, with the approval of the State Board of Education, shall develop and implement a plan for the coordination of services to handicapped children within each geographical area served by a regional education service center. The plan shall include, but may not be limited to, procedures for:

(1) identifying existing public or private educational and related services for handicapped children in each region;

(2) identifying and referring handicapped children who cannot be appropriately served by the school district in which they reside to other appropriate programs;

(3) assisting school districts individually and cooperatively to develop programs to identify and provide appropriate services for handicapped children;

(4) expanding and coordinating services provided by regional education service centers which are related to programs for handicapped children; and

(5) providing for special services such as special seats, books, instructional media, and other supplemental supplies and services required for quality instruction.

(c) The commissioner may allocate appropriated funds to regional education service centers and may otherwise expend those funds, as necessary, to implement the provisions of this section.

Coordinated Health Program (Cooperation in Establishment of Program)

Section BB-12.0

Tex. Rev. Civ. Stat. Ann., Art. 4447a, §1 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§1.

The Commissioners Court of any one or more counties and the municipal authorities of any one or more cities, towns, school boards and school districts, and any other governmental entity may cooperate in the establishment of a Health District and by mutual agreement may pro-

vide for the payment of costs, including the salaries of persons employed, materials used, and the provision of suitable office quarters, health and clinic centers, health services and facilities thereof, and for all maintenance purposes.

Health and Safety

Section BB-13.0

*19 Tex. Admin. Code §61.91 (McGraw-Hill, 1981).***§61.91. Student Health, Safety, and Well-Being**

It shall be the responsibility of school districts to adopt and implement policies designed to protect and promote the health, safety, and well-being of its pupils. These policies shall include, but shall not be restricted to, the following items:

(1) Provisions shall be made for the examination for tuberculosis infection of students when the need for such examination is indicated, in accordance with guidelines for the Texas State Department of Health.

(2) Provisions shall be made for implementation of an immunization program in accordance with the requirements of law and the rules of the Texas State Department of Health and the State Board of Education. (Reference Texas Education Code §2.09.)

(3) Eye-protective devices shall be provided in accordance with Texas Education Code §21.909.

Health Services

Section BB-14.0

*19 Tex. Admin. Code §85.41 (McGraw-Hill, 1981).***§85.41. Health Services Program**

(a) School health services shall be considered as part of the educational program of the school children of Texas. These services shall be provided to all children through local education agencies, in accordance with the provisions of Subchapter D of Chapter 97 of this title (relating to Principles, Standards, and Procedures for the Accreditation of School Districts), and standards established by the Texas State Department of Health and in accordance with applicable laws. The local education agency shall ensure appropriate coordination of school health services, other student services, and related instructional programs.

(b) School health services shall be addressed by policies of the local board of trustees. Local policies shall address the following functions:

- (1) planning, development, and evaluation;
- (2) health counseling;
- (3) screening;

(A) vision (Texas Civil Statutes, Article 4419f);

and

(B) hearing;

(4) prevention and control of communicable diseases;

(A) immunization (Texas Education Code, §2.09); and

(B) exclusion and reporting of students or employees who have communicable diseases (Texas Civil Statutes, Article 4477);

(5) provision for emergency cases;

(6) consultation and coordination with other student services and related instructional programs to focus on the health-related needs of students and their families (including but not limited to special education and health education);

(7) liaison with community health resources;

(8) referral and follow-up to ensure that parents have been notified of identified problems and know how they can obtain needed services for their children;

(9) health appraisals of students;

(10) maintenance of pupil health records;

(11) reporting child abuse (Texas Civil Statutes, Article 3401 et seq.);

(12) administration of medication by school personnel (Texas Education Code, §21.914); and

(13) eye-injury reporting and eye-protective devices (Texas Education Code, §21.909).

Immunization Requirements in Texas

Section BB-15.0

Elementary and Secondary Schools and Institutions of Higher Education*25 Tex. Admin. Code §§97.61-97.77 (McGraw-Hill, 1981).***§97.61. Students Included in Requirements**

The immunization requirements are specified elsewhere in this policy statement and apply to all students

entering, attending, and/or transferring to public, private, or parochial schools, for example: preschool programs and kindergartens associated with elementary schools; elemen-

tary and secondary (junior and senior high) schools; academies, colleges; universities; and, schools for the blind, deaf, mentally ill, and mentally retarded.

§97.62. Exclusions from Compliance

Exclusions from compliance are allowable on an individual basis for medical contraindications; religious conflicts, and active duty with the armed forces of the United States. Students in these categories must submit evidence as specified in the law.

(1) *Medical contraindications.* The student must present an affidavit or a certificate signed by a physician, duly registered and licensed to practice medicine in the United States, in which it is stated that, in the physician's opinion, the immunization required would be injurious to the health and well-being of the applicant or any member of his or her family or household. Unless a lifelong condition is specified, the affidavit or certificate is valid only one year from the date signed by the physician, and must be renewed at that time for the exclusion to remain in effect.

(2) *Religious conflicts.* The student must present an affidavit signed by the applicant, or if a minor, by his or her parent or guardian stating that the immunization conflicts with the tenets and practice of a recognized church or religious denomination of which the applicant is an adherent or member; provided, however, that this exemption does not apply in times of emergency or epidemic declared by the commissioner of health.

(3) *Armed forces.* Students who can prove that they are serving on active duty with the armed forces of the United States are exempted from the requirements in this title.

§97.63. Required Immunizations

See §97.71 of this title (relating to Provisional Enrollment), and §97.77 of this title (relating to Remarks and Special Recommendations).

(a) The immunization of infants and young children often requires a larger number of doses of vaccine than does the immunization of older children and adults. This section establishes minimum requirements (three doses each) for immunization against diphtheria, tetanus, pertussis, and poliomyelitis for the admission of school-age children to schools. These requirements should in no way be interpreted as contrary to standing recommendations by this department or by the Academy of Pediatrics, which call for larger numbers of doses (four or five doses each) to be employed in the immunization of infants and young children against these diseases.

(b) Oral polio vaccine is the usual vaccine of choice for preventing polio; however, inactivated polio vaccine may be medically indicated for some students. The required number of doses and booster requirements for inactivated polio vaccine (IPV) differ from the requirements

for oral polio vaccine. (See §97.66 of this title (relating to Inactivated Polio Vaccine).) If a student fails to complete the oral polio vaccine series, and, upon medical advice, starts receiving IPV, then the IPV requirements specified in §97.66 of this title (relating to Inactivated Polio Vaccine) will apply.

(c) The following immunizations are required in the respective age groupings.

(1) Children less than five years of age.

(A) Children less than two months old: no immunizations required.

(B) Children two months of age, but not yet four months of age: one dose each of oral polio and diphtheria-tetanus-pertussis (DTP) vaccines.

(C) Children four months of age, but not yet six months of age: two doses each of oral polio and DTP vaccines.

(D) Children six months of age, but not yet 18 months of age: two doses of oral polio and three doses of DTP vaccines.

(E) Children 18 months of age, but not yet five years of age: three doses each of oral polio and DTP vaccines, and one dose each of measles and rubella vaccines. The dose of measles vaccine must have been received on or after the first birthday or during the calendar month of the first birthday; or a physician-validated history of measles illness must be provided. All children in this group must have also received mumps vaccine, or provide a physician-validated history of mumps illness. See §97.67 of this title (relating to Verification of Measles or Mumps Illness), for policies on the acceptance of histories of measles and/or mumps illnesses in lieu of the vaccines.

(2) Children or students five years of age or older enrolled in elementary or secondary schools. (See §97.65 of this title (relating to Pregnancy).)

(A) *Polio.* At least three doses of oral polio vaccine are required, provided at least one dose has been received on or after the fourth birthday. See §97.77(c) and (d) of this title (relating to Remarks and Special Recommendations). Polio vaccine is not required for persons 18 years of age or older.

(B) *Tetanus/diphtheria.* At least three doses of DTP and/or Td vaccines are required, provided at least one dose has been received on or after the fourth birthday. See §97.64(b) of this title (relating to Boosters), and §97.77(c) and (d) of this title (relating to Remarks and Special Recommendations).

(C) *Measles.* All students in this group must have received measles vaccine on or after the first birthday, or during the calendar month of the first birthday and since January 1, 1968, or provide a physician-validated history of measles illness. See §97.67 of this title (relating to Verification of Measles Illness).

(D) *Rubella*. One dose of rubella vaccine is required. Rubella vaccine is not required past the 12th birthday. See §97.77(f).

(E) *Mumps*.

Beginning September 1, 1981, all children or students nine years of age or less on September 1, 1981, will be required to have received mumps vaccine, or provide a physician-validated history of mumps illness. See §97.67 of this title (relating to Verification of Mumps Illness). On the first of September each year thereafter, children or students one year older as of September 1 of that year, will also be required to have received mumps vaccine or provide a physician-validated history of mumps illness. See the following table:

Effective Dates	Ages as of September 1
September 1, 1981	Thru 9
September 1, 1982	Thru 10
September 1, 1983	Thru 11
September 1, 1984	Thru 12
September 1, 1985	Thru 13
September 1, 1986	Thru 14
September 1, 1987	Thru 15
September 1, 1988	Thru 16
September 1, 1989	Thru 17
September 1, 1990	Thru 18 and older

(3) Students in institutions of higher education. See §97.65 of this title (relating to Pregnancy) and §97.77 (f) of this title (relating to Remarks and Special Recommendations).

(A) *Polio*. Polio vaccine is not required for persons eighteen years of age and older. For persons less than eighteen years of age, at least three doses of oral polio vaccine are required, of which at least one dose must have been received on or after the fourth birthday. See §97.77(c)(d).

(B) *Tetanus/diphtheria*. A minimum of three doses of Td is required, of which the last dose was administered within ten years. DTP doses may be credited to the three required doses. See §97.77(c)(d).

(C) Students in institutions of higher education may be exempted from the requirements of this title by their respective institutions.

§97.64. Boosters

(a) Boosters are not required for oral polio, rubella, and mumps vaccines.

(b) Reinforcing of "booster" doses of tetanus/diphtheria (Td) vaccine are required every 10 years after the dose obtained on or after the fourth birthday. See §97.63(2)(B).

§97.65. Pregnancy

Requirements for polio, measles, rubella, and mumps vaccines are waived during pregnancy. This does not apply to tetanus/diphtheria vaccine.

§97.66. Inactivated Polio Vaccine

This vaccine is the injectable type which is usually recorded as "IPV" or "Salk" on immunization records. A few students may need this type of polio vaccine instead of oral polio vaccine because of medical considerations. A student may be provisionally enrolled with a history of one dose of IPV, provided two more doses are taken at one- to two-month intervals, and a fourth dose is received six to 12 months later. A student will be in full compliance with the IPV requirements whenever he or she has received the four initial IPV doses and has received a dose every five years until the 18th birthday. If a student fails to receive the five-year IPV booster, but, upon medical advice, starts receiving oral polio vaccine, then the oral polio vaccine requirements specified in §97.63 will apply to the student.

§97.67. Verification of Measles or Mumps Illness

Section 97.63 of this title (relating to Required Immunizations) states that physician-validated histories of measles or mumps illnesses are acceptable in lieu of vaccine. All histories of measles or mumps illness must be supported by a written statement from a physician licensed to practice medicine in the United States. The physician's statement should contain wording such as "This is to verify that (name of student) had measles or mumps illness on or about (date) and does not need measles or mumps vaccine." A copy of the statement must be attached to the student's school immunization record, and the original returned to the student, parent, or guardian. Note: If a student is unable to submit a physician's statement, then measles or mumps vaccine is required.

§97.68, §97.69, and §97.70 Repealed

§97.71. Provisional Enrollment

The law requires that students be fully immunized against the specified diseases. However, a student may be provisionally admitted if he or she has begun the required immunizations and if he or she continues to receive necessary immunizations as rapidly as is medically feasible. The school granting provisional enrollment must ensure that the required immunizations are received on schedule. If a student transfers from one school to another, a grace period of no more than 30 days may be allowed at the new school while awaiting the transfer of the immunization record, during which the student may be provisionally enrolled.

§97.72. School Records

All schools are required to maintain records of the immunization status of individual students. The records must be made available for inspection by representatives of the Texas Education Agency, the Texas Department of Health, or local health departments, at all reasonable times.

§97.73. Acceptable Documents of Immunizations

Any validated document of immunization presented by a student is acceptable, provided it shows at least the month and year when each immunization was received. At least the month and year of vaccine or disease must be recorded in all new school records initiated, and in existing records updated, after September 1, 1978. The month, day, and year of immunizations or diseases should be recorded whenever possible. All new entries in immunization files must be based upon a certificate of immunization which has been validated by, or for, a physician or public health personnel. The validated record should be returned to the student or the student's parent or guardian after the immunization history has been entered in school records. The Texas Department of Health and local health departments will provide record-keeping cards free of charge for maintaining school immunization files, or commercially or locally produced record cards may be used.

§97.74. Transfer of Records

When a student transfers from one school or district to another, a copy of the immunization record and any measles or mumps illness statements from physician should be sent within 30 days to the receiving school. A record received by mail from school officials of another district or state may be considered a validated record.

§97.75. Assistance and Review of Records

Representatives of the Texas Department of Health and local health departments will, upon request, advise and assist school administrators in meeting the requirements of the law. Representatives of the Texas Education Agency review immunization records when annual immunization reports are submitted, and again when schools are visited for accreditation purposes. Periodic review of school immunization records is occasionally necessary in order to allow public health epidemiologists to obtain information required in preventing or controlling community outbreaks of vaccine-preventable diseases.

§97.76. Annual Report of Immunization Status

Annual reports of the immunization status of students as of a specified date shall be required of all public school districts and private schools so that compliance with the legislation may be monitored. Data derived from these

reports are published jointly by the Texas Education Agency and the Texas Department of Health.

§97.77. Remarks and Special Recommendations

(a) Immunization recommendations vary from state-to-state and from physician-to-physician. The immunization requirements specified herein will assure protection against the vaccine-preventable diseases for the majority of students. Some physicians and local health departments adhere to an immunization schedule which may require more doses than other physicians; therefore, many students will have received more doses of vaccine than those specified above.

(b) If there is an epidemic of vaccine-preventable disease in or near a community, the local health authority may require or recommend additional doses or boosters to provide further protection for students attending schools and institutions of higher education.

(c) If a dose of oral polio or DTP/Td vaccine is administered within the calendar month prior to, or of, the fourth birthday, it will satisfy the requirement for a dose on or after the fourth birthday.

(d) When a validated immunization record contains only one vaccine date for either oral polio or DTP/Td, and a "B" or the word "booster," or the words "series completed" (or similar wording) appears by the immunization date, assume that three doses of the vaccine have been administered. If the date is within the month prior to, or of, the fourth birthday, then the requirement for a dose on or after the fourth birthday is met under these circumstances.

(e) The requirements for mumps vaccine will apply to one higher age each year until all students are included.

(f) Rubella immunizations are not required for students 12 years of age and older. Previously unimmunized females 12 and older should be serologically tested for rubella and referred to their usual source of medical care if the tests indicate susceptibility to rubella.

(g) Authorities in schools and institutions of higher education are strongly encouraged to report on the day of recognition all suspected or known cases of vaccine-preventable diseases, which occur among students or staff, to the city or county health department, the city or county health officer, the public health regional office, or the Texas Department of Health in Austin, thus alerting health officials to possible outbreaks of these diseases.

Immunization; Requirements; Exceptions

Section BB-16.0

Tex. Educ. Code Ann. §§2.09, 2.09a (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§2.09.

(a) No person may be admitted to any elementary or secondary school or institution of higher education unless he has been immunized against diphtheria, rubeola, rubella, tetanus, and poliomyelitis, except as provided in Subsection (c).

(b) Subject to the provisions of Subsection (c), the Texas Board of Health may modify or delete any of the immunizations in Subsection (a) or may require immunizations against additional diseases as a requirement for admission to any elementary or secondary school or institution of higher education.

(c) No form of immunization is required for a person's admission to any elementary or secondary school or institution of higher education when the person applying for admission:

(1) submits to the admitting official either of the following:

(A) an affidavit or a certificate signed by a physician who is duly registered and licensed to practice medicine within the United States, in which it is stated that, in the physician's opinion, the immunization required would be injurious to the health and well-being of the applicant or any member of his family or household; or

(B) an affidavit signed by the applicant or, if a minor, by his parent or guardian stating that the immunization conflicts with the tenets and practice of a recognized church or religious denomination of which the applicant is an adherent or member; provided, however, that this exemption does not apply in times of emergency or epidemic declared by the Commissioner of Health; or

(2) is a member of the armed forces of the United States and is on active duty.

(d) The Texas Department of Health shall provide the required immunizations to children in areas where no local provision exists to provide these services.

(e) A person may be provisionally admitted to an elementary or secondary school or institution of higher education if he has begun the required immunizations and if he continues to receive the necessary immunizations as rapidly as is medically feasible. The Texas Department of Health shall promulgate rules and regulations relating to the provisional admission of persons to an elementary or secondary school or institution of higher education.

§2.09a. Immunization Records; Reporting

(a) Each school or institution of higher education covered by this Act shall keep an individual immunization record during the period of attendance for each student admitted, and the records shall be open for inspection at all reasonable times by the Central Education Agency or by representatives of local health departments or the Texas Department of Health.

(b) Each school or institutions of higher education covered by this Act shall cooperate in transferring students' immunization records between other schools and institutions of higher education. Specific approval from students, parents, or guardians is not required prior to making such record transfers.

(c) The Central Education Agency and the Texas Department of Health shall develop the form for a required annual report of the immunization status of students and such annual report shall be submitted by all Texas schools at such time and in such manner as is indicated in the instructions printed on such form.

Duties of Professional Employees; Liability

Section BB-17.0

Tex. Educ. Code Ann. §21.912, (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.912.

(a) The board of trustees of each school district within this state shall adopt policies specifying the duties of each of its professional positions of employment. The board of trustees shall assign positions of employment earned under the minimum foundation program to meet the specific needs of the district.

(b) No professional employee of any school district within this state shall be personally liable for any act incident to or within the scope of the duties of his position of employment, and which act involves the exercise of judgment or discretion on the part of the employee, except in

circumstances where professional employees use excessive force in the discipline of students or negligence resulting in bodily injury to students.

(c) This section is not applicable to the operation, use, or maintenance of any motor vehicle.

(d) "Professional employee," as used in this section, includes superintendents, principals, classroom teachers, supervisors, counselors, and any other person whose employment requires certification and an exercise of discretion.

Consent to Medical Treatment

Section BB-18.0

Tex. Fam. Code Ann. §§35.01, 35.02, 35.03 (Vernon 1975). Tex. Fam. Code Ann. §35.04 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§35.01. Who May Consent

Any of the following persons may consent to medical treatment of a minor when the person having the power to consent as otherwise provided by law cannot be contacted and actual notice to the contrary has not been given by that person:

- (1) a grandparent;
- (2) an adult brother or sister;
- (3) an adult aunt or uncle;
- (4) an educational institution in which the minor is enrolled that has received written authorization to consent from the person having the power to consent as otherwise provided by law;
- (5) any adult who has care and control of the minor and has written authorization to consent from the person having the power to consent as otherwise provided by law; or
- (6) any court having jurisdiction of the child.

§35.02. Consent Form

(a) Consent to medical treatment under Section 35.01 of this code shall be in writing, signed by the person giving consent, and given to the doctor, hospital, or other medical facility that administers the treatment.

(b) The consent must contain:

- (1) the name of the minor;
- (2) the name of one or both parents, if known, and the name of the managing conservator or guardian of the person, if either has been appointed;
- (3) the name of the person giving consent and his relation to the minor child;
- (4) a statement of the nature of the medical treatment to be given; and
- (5) the date on which the treatment is to begin.

§35.03. Consent to Treatment by Minor

(a) A minor may consent to the furnishing of hospital, medical, surgical, and dental care by a licensed physician or dentist if the minor:

- (1) is on active duty with the armed services of the United States of America;
- (2) is 16 years of age or older and resides separate and apart from his parents, managing conservator, or guardian, whether with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of such residence, and is managing his own financial affairs, regardless of the source of the income;
- (3) consents to the diagnosis and treatment of any infectious, contagious, or communicable disease which is required by law or regulation adopted pursuant to law to

be reported by the licensed physician or dentist to a local health officer;

(4) is unmarried and pregnant, and consents to hospital, medical, or surgical treatment, other than abortion, related to her pregnancy;

(5) is 18 years of age or older and consents to the donation of his blood and the penetration of tissue necessary to accomplish the donation; or

(6) consents to examination and treatment for drug addiction, drug dependency, or any other condition directly related to drug use.

(b) Consent by a minor to hospital, medical, surgical, or dental treatment under this section is not subject to disaffirmance because of minority.

(c) Consent of the parents, managing conservator, or guardian of a minor is not necessary in order to authorize hospital, medical, surgical, or dental care under this section.

(d) A licensed physician or dentist may, with or without the consent of a minor who is a patient, advise the parents, managing conservator, or guardian of the minor of the treatment given to or needed by the minor.

(e) A physician or dentist licensed to practice medicine or dentistry in this state or a hospital or medical facility shall not be liable for the examination and treatment of minors under this section except for his or its own acts of negligence.

(f) A physician, dentist, hospital, or medical facility may rely on the written statement of the minor containing the grounds on which the minor has capacity to consent to his own medical treatment under this section.

§35.04. Examination of Abused or Neglected Children

(a) Except as provided in Subsection (b) of this section, a licensed physician or dentist having reasonable grounds to believe that a child's physical or mental condition has been adversely affected by abuse or neglect may examine the child without the consent of the child, the child's parents, or other person authorized to consent for the child or his parents. The examination may include X-rays, blood tests, and penetration of tissue necessary to accomplish these tests.

(b) Unless consent is obtained as otherwise allowed by law, a physician or dentist may not examine a child:

(1) who is 16 years old or over and refuses to consent; or

(2) if consent is refused by an order of a court.

(c) A physician or dentist examining a child under the authority of this section is not liable for damages except those damages resulting from his negligence.

Administering of Medication by School District Employees; Immunity From Liability

Section BB-19.0

Tex. Educ. Code Ann. §21.914 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.914.

(a) As used in this section, "employees" means superintendents, principals, classroom teachers, supervisors, counselors, registered nurses, teachers aides, secretaries, or any other classified person employed by a school district.

(b) The board of trustees of each school district shall adopt policies concerning the administering of medication to students by employees of the district.

(c) On the adoption of policies as provided in Subsection (b) of this section, the school district, its board of trustees, and its employees shall have immunity from civil

liability from damages or injuries resulting from the administering of medication to a student, if:

(1) the school district has received a written request to administer the medication from the parent, legal guardian, or other person having legal control of the student; and

(2) when administering prescription medication, the medication appears to be in the original container and to be properly labeled.

(d) Nothing herein shall be construed to grant immunity from civil liability for injuries resulting from gross negligence.

Nurse Practice Act (Registered Nurse)

Section BB-20.0

Tex. Rev. Civ. Stat. Ann., Art. 4518 §5 (Vernon Supp. 1982).

§5.

Insofar as any of the following acts require substantial specialized judgment and skill and insofar as the proper performance of any of the following acts is based upon knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing, 'Professional Nursing' shall be defined as the performance for compensation of any nursing act (a) in the observation, assessment, intervention, evaluation, rehabilitation, care

and counsel and health teachings of persons who are ill, injured or infirm or experiencing changes in normal health processes; (b) in the maintenance of health or prevention of illness; (c) in the administration of medications or treatments as prescribed by a licensed physician or dentist; (d) in the supervision or teaching of nursing; (e) in the administration, supervision, and evaluation of nursing practices, policies, and procedures. The foregoing shall not be deemed to include acts of medical diagnosis or prescription of therapeutic or corrective measures.

Open Records Act

Section BB-21.0

Tex. Rev. Civ. Stat. Ann., Art 6252-17a, §14 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§14. Interpretation of this Act

(a) This Act does not prohibit any governmental body from voluntarily making part or all of its records available to the public, unless expressly prohibited by law; provided that such records shall then be available to any person.

(b) This Act does not authorize the withholding of information or limit the availability of public records to the public, except as expressly so provided.

(c) This Act does not give authority to withhold information from individual members or committees of the Legislature of the State of Texas to use for legislative purposes.

(d) This Act shall be liberally construed in favor of the granting of any request for information.

(e) Nothing in this Act shall be construed to require the release of information contained in education records of any educational agency or institution except in conformity with the provisions of the Family Educational Rights and Privacy Act of 1974, as enacted by Section 513 of Public Law 93-380, codified as Title 20 U.S.C.A. Section 1232g, as amended.

Control and Eradication of Pediculosis in Minors Section BB-22.0

Tex. Rev. Civ. Stat. Ann., Art. 6547k, §§1, 2 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§1.

The State Department of Health shall establish and develop a state program for the control and eradication of pediculosis of a minor. This program may include procedures for detection and instructions for treatment of same.

§2.

A parent or guardian of a minor who has been found to have pediculosis shall follow the instructions of the State Department of Health or shall place the minor under the care of a licensed physician for the purpose of treating the infestation of pediculosis of a minor.

Pilot Programs for Physical Evaluations of School Children Section BB-23.0

Tex. Educ. Code Ann. §11.20 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA AD1 013 01.

§11.20

(a) The Central Education Agency shall plan, institute, and supervise pilot programs in various school districts of this state for the purpose of screening children for health defects or problems.

(b) In each district selected for a pilot program, children shall be examined or evaluated in the manner prescribed by the Central Education Agency and by nurses or other allied health personnel specifically authorized to do so by the agency.

(c) Prior notice of the examination shall be given to the parents or guardian of each child, and no child shall be examined or evaluated if his parents or guardian object because of religious convictions.

(d) Whenever an abnormal health condition or problem is found in any child, the school nurse shall:

- (1) advise the child's parent or guardian;
- (2) suggest what action should be taken;
- (3) if necessary, assist the family in obtaining ac-

cess to appropriate health, rehabilitation, or treatment services; and

(4) review the case as necessary to determine that corrective action is taken to the extent possible.

(e) The agency shall require a record to be kept of each examination and actions taken pursuant to each examination. The record shall be confidential and shall be kept separate from the other records of the child. The records may be used for statistical purposes as long as the identity of each child is kept confidential.

(f) The agency shall require periodic reports from each district participating in the program for the purpose of evaluating the results of the program. The agency shall report its findings and recommendations to the legislature biennially during the first month of the regular session.

(g) The legislature shall appropriate money to finance the cost of the program, including planning, compensation for personal services, and necessary equipment and supplies.

Duties of Public School Principals

Section BB-24.0

Tex. Educ. Code Ann. §21.913 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§21.913

(a) Public school principals, who shall hold valid administrative certificates, shall be responsible for:

(1) assuming administrative responsibility and instructional leadership, under the supervision of the superintendent, for discipline, and the planning, operation, supervision, and evaluation of the educational program of the membership area in which he is assigned;

(2) submitting recommendations to the superintendent concerning assignment, evaluation, promotion and dismissal of all personnel assigned to the membership center; and

(3) performing any other duties assigned by the superintendent pursuant to school board policy.

(b) Nothing herein shall be construed as a limitation on the powers, responsibilities, and obligations of the school board as now prescribed by law.

Quarantine and Disinfection

Section BB-25.0

Tex. Rev. Civ. Stat. Ann., Art. 4477, Rules 15, 16, 26-30 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

Rule 15. Quarantinable for School Purposes.

Persons suffering from measles, whooping cough, mumps, German measles (rubella) and chicken pox, shall be required to be barred from school for twenty-one days (at the discretion of the local health officer) from date of onset of the disease, with such additional time as may be deemed necessary; and may be readmitted on a certificate by him attesting to their recovery and non-infectiousness.

Rule 16. Minor Diseases to be Excluded During Illness.

Those actually suffering from tonsillitis, scabies (itch), impetigo contagiosa, favus, shall be excluded from school during such illness and be readmitted on the certificate of the attending physician attesting to their recovery and non-infectiousness.

Rule 26. Persons Excluded From Schools.

Persons afflicted with trachoma, granulated lids, or contagious catarrhal conjunctivitis must be excluded from schools, public assemblages, and from close association with other individuals, unless they are under the constant care and strict supervision of a competent physician, and hold a certificate from said physician stating that active inflammation has subsided, said certificate to be countersigned by a local health authority.

Rule 27. Schools Temporarily Closed.

A schoolhouse wherein a child suffering from smallpox, scarlet fever or diphtheria has been present, shall be deemed infected and must be temporarily closed and thoroughly disinfected and cleaned under the supervision of the local health authority before reopening of the school.

Rule 28. School to Open After Disinfection.

In the event of the aforementioned disease being smallpox and in the case the Board of Trustees having passed a regulation requiring a successful vaccination of all teachers and pupils, the school may be reopened immediately after the disinfection and cleaning, and all teachers and pupils who have been successfully vaccinated may return; otherwise the school shall be kept closed eighteen days or until the local health authority directs otherwise.

Rule 29. To Notify Superintendents of Pupils From Infected Houses.

The local health authority shall notify the superintendent or principal of any school of the location of quarantinable diseases, and if the superintendent or principal finds any attendants in such school who live in said houses, he shall deny them admission to the said schools, only admitting them again upon presenting a certificate from the attending physician, countersigned by the local health authority, that there is no longer danger from contagion.

Rule 30. Children with Diseases Shall Not Attend School.

No superintendent, principal or teacher of any school, and no parent, master or guardian of any child or minor, having the power and authority to prevent, shall permit any child or minor, having any quarantinable disease, or any child residing in any house in which any such disease exists or has recently existed, to attend any public, private, parochial, church, or Sunday school until the requirements of these rules have been complied with.

Rights, Privileges, and Obligations of 18-Year-Olds Section BB-26.0

Tex. Rev. Civ. Stat. Ann., Art. 5923b, §§1-2 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§1.

The purpose of this Act is to extend all the rights, privileges, and obligations of majority to all persons who are at least 18 years of age. It shall be construed liberally to accomplish that purpose.

§2.

Notwithstanding any statutory or decisional law, or any rule, regulation, or ordinance of this state or of any political subdivision or incorporated city or town of this state, a person who is at least 18 years of age has all the rights, privileges, and obligations of a person who is 21

years of age. A law, rule, regulation, or ordinance which extends a right, privilege, or obligation to a person on the basis of a minimum age of 21, 20, or 19 years shall be interpreted as prescribing a minimum age of 18 years.

It is specifically provided, however, that with respect to property held by a custodian under the Texas Uniform Gifts to Minors Act, as amended (Article 5923-101, Vernon's Texas Civil Statutes), on effective date hereof and the proceeds and reinvestments thereof, the custodian may elect not to have the provisions of this Act apply by so notifying the minor in writing, but such election may be revoked at the election of the custodian.

Sanitation and Health Protection

Section BB-27.0

Tex. Rev. Civ. Stat. Ann., Art. 4477-1, §§6, 8, 16 (Vernon Supp. 1976). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§6. Toilet Facilities

All operators, managers, or superintendents of any public buildings, school houses, theaters, filling stations, tourist courts, bus stations and taverns shall provide and maintain sanitary toilet accommodations.

§8. Public Buildings

Any and all public buildings hereafter constructed shall have incorporated therein all such heating, ventilation, plumbing, screening, and ratproofing features as may be necessary to properly protect the health and safety of the public.

§16. School Houses and Grounds

(a) Every school building shall be located on grounds that are well drained and maintained in a sanitary condition.

(b) Every school building shall be properly ventilated and provided with an adequate supply of drinking water and approved sewage disposal system, hand-washing facilities, a heating system, and lighting facilities, all of which shall conform with established standards of good public health engineering practices.

(c) All public school lunch rooms maintained and operated shall comply with the State Food and Drug Regulations.

(d) All public school buildings and appurtenances thereto shall be maintained in a sanitary manner.

(e) All building custodians and janitors employed on a full-time basis shall be versed in the fundamentals of safety and school sanitation.

**Comprehensive Special Education Program
For Handicapped Children**

Section BB-28.0

Tex. Educ. Code Ann. §16.104 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§16.104.

(a) The commissioner of education, with the approval of the State Board of Education, shall develop, and modify as necessary, a statewide design for the delivery of services to handicapped children in Texas which includes rules for the administration and funding of the special education program so that a free appropriate public education is available to all handicapped children between the ages of three and 21 by no later than September 1, 1980. The statewide design shall include, but may not be limited to, the provision of services primarily through local school districts and special education cooperatives, supplemented by a regional delivery structure. The commissioner shall further develop and implement a statewide plan with programmatic content which includes procedures designed to:

(1) ensure state compliance with requirements for supplemental federal funding for all state-administered programs involving the delivery of instructional or related services to handicapped students as defined in this section;

(2) facilitate interagency coordination when state agencies other than the Central Education Agency are involved in the delivery of instructional or related services to handicapped students;

(3) assess statewide personnel needs in all areas of specialization related to special education on a periodic basis and pursue strategies to meet those needs through

a consortium of representatives from regional education service centers, local education agencies, and institutions of higher education and through other available alternatives;

(4) ensure that regional education service centers throughout the state maintain a regional support function, which may include direct service delivery and a component designed to facilitate the placement of handicapped students who cannot be appropriately served within their resident districts;

(5) allow the Central Education Agency to effectively monitor and periodically conduct site visits of all local districts to ensure that agency rules adopted under this section are applied in a consistent and uniform manner, to ensure that districts are complying with those rules, and to ensure that annual statistical reports filed by the districts are accurate and complete;

(6) ensure the availability of sequentially related, field-based, inservice special education training programs for regular and special educators serving handicapped students and further ensure that all local districts dedicate at least the equivalent of one full day of their required inservice program per school year to that special education inservice training for those personnel;

(7) ensure that appropriately trained personnel are involved in the diagnostic and evaluation procedures

operating in all local districts and that those personnel routinely serve on local district admissions, review, and dismissal teams;

(8) ensure that an individualized education plan for each handicapped student is properly developed, implemented, and maintained in the least restrictive environment which is appropriate to meet the student's educational needs;

(9) ensure that, when appropriate, each handicapped student is provided an opportunity to participate in vocational and physical education classes, in addition to participation in regular or special classes; and

(10) ensure that each handicapped student is provided necessary related services.

(b) As used in this section:

(1) "Special services" means:

(A) "special teaching," which may be provided by professional and paraprofessional personnel in the following instructional settings:

(i) resource room;

(ii) self-contained classroom, regular or special campus;

(iii) hospital or community class;

(iv) homebound or bedside;

(v) speech or hearing therapy class; or

(B) "related services," which are developmental, corrective, supportive, or evaluative services, not instructional in nature, that may be required for the proper development and implementation of a handicapped student's individualized educational plan, including but not limited to special transportation, school health services, counseling with students or families, psychological services, audiological services, visual training, medical or psychiatric diagnostic services, occupational therapy, physical therapy, recreational therapy, social work services, parent counseling and training, adaptive equipment, special seating, orientation and mobility training, speech therapy, music therapy, and corrective therapy.

(2) "Resident district" means the local school district in which the parent or other person who has the primary legal obligation for care, control, and custody of a handicapped student resides, except that if the state is managing conservator of the student, the resident district is the district within which the student is placed by the state.

(c) The commissioner, with the approval of the State Board of Education, shall develop specific eligibility criteria based on the general classifications established by this section with reference to contemporary diagnostic or evaluative terminologies and techniques. Eligible handicapped students shall enjoy the right to a free appropriate public education, which may include instruction in the regular classroom, instruction through special teaching, or instruction through contracts approved under this section. Instruction shall be supplemented by the provision of related services when appropriate. The following classifica-

tions of handicapped students shall serve as the general eligibility criteria for participation in a district's special education program:

(1) "Handicapped students" means students between the ages of 3 and 21, inclusive;

(A) with educational handicaps (physically handicapped, auditorially handicapped, visually handicapped, mentally retarded, emotionally disturbed, learning disabled, speech handicapped, autistic, or multiply handicapped); and children leaving and not attending public school for a time because of pregnancy; and

(B) whose disabilities are so limiting as to require the provision of special services in place of or in addition to instruction in the regular classroom.

(2) "Physically handicapped students" means students whose body functions or members are so impaired from any cause that they cannot be adequately or safely educated in the regular classes of the public schools without the provision of special services.

(3) "Auditorially handicapped students" means students whose hearing is so impaired that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

(4) "Visually handicapped students" means students whose sight is so impaired that they cannot be adequately or safely educated in the regular classes of the public schools without the provision of special services.

(5) "Mentally retarded students" means students with significantly subaverage general intellectual functioning existing concurrently with deficiencies in adaptive behavior and manifested during the developmental period such that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

(6) "Emotionally disturbed students" means students whose emotional condition is psychologically or psychiatrically determined to be such that they cannot be adequately and safely educated in the regular classes of the public schools without the provision of special services.

(7) "Learning disabled students" means students:

(A) who demonstrate a significant discrepancy between academic achievement and intellectual abilities in one or more of the areas of oral expression, listening comprehension, written expression, basic reading skills, reading comprehension, mathematics calculation, mathematics reasoning, or spelling;

(B) for whom it is determined that the discrepancy is not primarily the result of visual handicap, hearing impairment, mental retardation, emotional disturbance, or environmental, cultural, or economic disadvantage; and

(C) for whom the inherent disability exists to a degree such that they cannot be adequately served in the regular classes of the public schools without the provision of special services.

(8) "Speech handicapped students" means students whose speech is so impaired that they cannot be adequately educated in regular classes of the public schools without the provision of special services.

(9) "Autistic students" means students whose disturbances of speech and language, relatedness, perception, developmental rate, and motility are such that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

(10) "Multiply handicapped students" means students handicapped by any two or more of the handicapping conditions described in Subdivisions (2) through (9) of this subsection that may result in multisensory or motor deficiencies and developmental lags in the cognitive, affective, or psychomotor areas such that they cannot be adequately educated in the regular classes of the public schools without the provision of special services.

Student Services

Section BB-29.0

19 Tex. Admin. Code §85.1 (McGraw-Hill 1981).

§85.1. Scope

(a) As part of the public education program, student services shall include guidance services, student health services, and attendance services (§97.96 (5) (226.37.15.250) of this title (relating to Principle 5)).

(b) Student services may also include home/school coordination, school psychological services, school lunch and child nutrition services, and transportation. Note: Cer-

tain school districts are required to participate in the national school breakfast program in accordance with Texas Education Code §21.914.

(c) Districts which provide services listed in subsection (b) of this section shall comply with relevant law and State Board of Education policies and their corresponding administrative procedures.

Tuberculosis, Examining Public School Personnel

Section BB-30.0

25 Tex. Admin. Code §§97.91-97.97 (McGraw-Hill 1981).

§97.91. Categories of Employees and Volunteers

The following categories of employees and volunteers in Texas public schools are subject to examination, provided that the accumulated time of employment or volunteer service in the school is expected to be more than 90 hours for each school year by each such employee or volunteer: teachers, teachers aides and other classroom personnel, coaches and trainers, bus drivers, librarians, nursing and health personnel, supervisory personnel, clerical personnel, counselors, foodhandlers, persons performing custodial duties or janitorial duties.

§97.92. Certificate of Examination

The form and content of the certificate of examination shall be substantially as illustrated below, provided that another form may be used if all the elements of the standard form are embodied in it. A certificate issued on or after April 15, 1978, but before the effective date of this section shall be valid if it embodies the information contained in the standard form and is signed by a physician licensed to practice medicine in Texas.

§97.93. Closing Date for Filing Certificate

The closing date for filing of individual certificates with the governing body of the Texas public school shall

be the date on which the individual is to commence duties at the school; those duties shall not commence until the certificate has actually been received by the governing board or its authorized representatives.

§97.94. Transfer of Certificate Between School Districts

An original or true and correct copy of a certificate shall be honored by the governing body of school on transfer of an employee or volunteer from another Texas public school provided that the certificate is complete and valid and further provided that not more than 120 days will have elapsed in employment in a Texas public school.

§97.95. Expiration and Frequency of Certificates

A certificate shall expire and a new certificate shall be required if more than 120 days shall have elapsed since employment or volunteer service in a Texas public school.

§97.96. Reexaminations

An employee or volunteer shall be required to produce a new certificate of examination within 30 days of notification of the governing board by the local health authority or the Texas Department of Health that the individual has been exposed to a reported case of tuberculosis

or has had probable exposure to a case of tuberculosis, regardless of whether the actual identity of the case has been determined or not.

§97.97. Reporting Results of Examination

The results of the examinations and reexaminations shall be reported to the Texas Department of Health Bureau of Tuberculosis Services by the governing body of

each school, over signature of the superintendent of the school, not later than 30 days after the start of each school year. The results shall be reported on a standard form developed and revised as deemed necessary by the Texas Department of Health, with such copies as the department may deem necessary. The initial version of this form is illustrated below (Form No. TB-5) and may be reproduced locally if desired.

Prevention, Eradication, and Control of Tuberculosis Section BB-31.0

Tex. Rev. Civ. Stat. Ann., Art. 4477-12, §§4, 5 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§4. Examination of Pupils for Tuberculosis Infection.

The Texas Board of Health Resources may provide for the examination for tuberculosis infection of pupils in the first and seventh grades of the public, parochial and private schools of this state, and of pupils transferred to public, parochial and private schools of this state from another state or country.

§5. Certificate of Examination of School Personnel

(a) The governing body of each public school within the State shall require that each individual who is employed by or who acts as a volunteer for the governing body, and who is included within certain categories designated by the Texas Board of Health, shall present to the governing body a certificate, signed by a physician licensed to practice medicine in Texas, which states that the individual has been examined for tuberculosis and discloses the results of the examination. The governing body of each public school shall verify that each individual within its jurisdiction who is included within this Act, has the required certificate and shall not permit any individual to commence his or her duties in the absence of the certificate. The Texas Board of Health may require reexamination of any individual employee or volunteer as the Board determines is necessary and appropriate to protect the public health.

(b) The Texas Board of Health shall adopt rules describing the following:

(1) the designation of the categories of employees or volunteers who are required to be examined;

(2) the form and content of the required examination certificate;

(3) the closing dates for filing such individual certificates;

(4) the transfer of such individual certificates between public school districts;

(5) the frequency of such required examinations;

(6) the criteria for requiring reexaminations; and

(7) the reporting of the results of such examinations to the Texas Department of Health.

(c) This section and the rules adopted by the Texas Board of Health by the authority of this Act, shall be the minimum acceptable standards for the examination of the named categories of individuals for tuberculosis. A school district may adopt and enforce more stringent standards, except that the requirements for a tuberculosis examination may not include exposure of X-rays unless the person being examined consents or the examining physician determines that the X-ray examination is medically necessary and states that determination on the required certificate.

Children's Vision Screening Act of 1979

Section BB-32.0

Tex. Rev. Civ. Stat. Ann., Art. 4419F, (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§ 1. Short Title

This Act shall be known as and may be cited as "The Texas Children's Vision Screening Act of 1979."

§2. Purpose

The purpose of children's vision screening is to identify those children who need a thorough eye examination by a professional eye examiner. Such screening is particularly necessary in early childhood since many visual

defects will become incurable if detected too late. Screening is not a diagnostic procedure and decisions about the need for treatment can only be made after a professional eye examination. Besides discovering vision defects which may interfere with the child's education, vision screening helps the teacher prepare assessments of the child's educational potential and helps to detect those children who are needing special educational services because of insufficient vision. It shall not be the intent of the legislature to im-

pose any added fiscal implications or additional costs on units of local government.

§3. Definitions

(a) "Board" means the Texas Board of Health.

(b) "Department" means the Texas Department of Health.

(c) "Vision screening" means a test or battery of tests for rapid determination of the need for a more complete visual examination by an eye specialist.

§4. Children's Vision Screening Required; Exception

(a) It is required for all children enrolling in any public, private, parochial, or denominational school in Texas for the first time, that the parent, managing conservator, or other person having a legal responsibility for the child's support shall submit to the admitting officer of the school within 90 days after admission a certificate which states that the child has either (1) been examined by a physician licensed to practice in the United States or an optometrist licensed to practice in the United States or (2) undergone a vision screening test which has been approved by the board and which discloses the results of the examination or test.

(b) Subject to the exception in Subsection (c) of this section, the board may by rule modify the requirement of Subsection (a) to require the additional periodic examination or screening of children it determines is necessary.

(c) A child may be provisionally admitted to a kindergarten, elementary, or secondary school upon the submission of an affidavit signed by the parent, managing conservator, or person having a legal responsibility for the child's support, that the child will undergo the required vision screening test or examination as rapidly as is feasible.

(d) The requirements of this section are mandatory except in the event that the affected child's parent, managing conservator, or person having a legal responsibility for the child's support presents to the school authorities an affidavit signed by the parent, managing conservator, or person having a legal responsibility for the child's support stating that the visual screening test conflicts with the tenets or practices of a recognized church or religious denomination of which the affiant is an adherent or a member.

(e) The governing body of each school shall ensure that all parents, managing conservators, or persons having a legal responsibility for the support of school children within the jurisdiction of the governing body present the required certificate of examination or screening, or an affidavit of exemption based on religious tenet or practice.

§5. Required Certificate.

(a) The certificate required shall be in a form prescribed by the board and shall contain that information

which may be required by the board to carry out the intent of this Act.

(b) The certificate may be signed by:

(1) a physician licensed to practice in the State of Texas or an optometrist licensed to practice in the United States who performed the eye examination;

(2) a physician licensed to practice in the State of Texas or an optometrist licensed to practice in the United States who personally supervised a vision screening test; or

(3) health personnel, volunteers, school nurses or aides, or other school personnel who have undergone a special training program in the administration of children's vision screening testing which meets the standards approved by the board.

(c) The requirement of Section 4 may be met by an entry made in the official school record of the child which states that the child has undergone a vision screening test which meets the standards set by the board, that the test was administered by a person authorized in this section to sign the required certificate, and which discloses the results of the test.

§6. Examination or Test Records; Reporting

(a) Each school covered by this Act shall keep an individual eye examination or vision screening record for each student during the period of attendance for each child admitted, and the records shall be open for inspection at all reasonable times by representatives of the local health departments or the Texas Department of Health.

(b) Each school covered by this Act shall cooperate in transferring student's eye examination or vision screening records between other schools. Specific approval from the parent, managing conservator, or other person having a legal responsibility for the child's support is not required prior to making such transfers.

(c) The department shall develop the form for a required annual report of the results of the examinations or tests and the report will be submitted according to the instructions of the board.

§7. Powers of the Texas Board of Health

(a) The board is authorized to establish a vision screening program in the department.

(b) The board, in consultation with the advisory committee, shall adopt rules to carry out the intent of this Act. These rules shall include, but not be limited to, rules prescribing the following:

(1) form and content of the required certificate;

(2) the closing dates for presenting such certificates;

(3) transfer of individual certificates between schools;

(4) criteria for rescreening and referral;

(5) reporting of results and referrals to the department;

(6) standards required for vision screening tests and screener training courses to ensure excellence and uniformity in the vision screening program.

(c) The board acting through the department and in consultation with the advisory committee shall:

(1) train or approve the training of persons who will administer vision screening tests;

(2) monitor the quality of screening activities in an appropriate manner;

(3) directly or through local health departments or regional public health offices, assist school districts and other organizations in developing programs to provide vision screening for children;

(4) compile and publish statistical analyses of reports relating to examination and screening results and referrals to ascertain the impact of the requirements on public health.

§8. Advisory Committee on Vision Screening

The board shall appoint an advisory committee on children's vision to consult with and advise the board in determining acceptable technical and professional standards which must be met by any individual or public or private health care entity undertaking to perform the vision screening tests allowed in Section 4 of this Act. The advisory committee will also advise the board on referral and appropriate follow-up.

(a) The advisory committee shall be composed of:

(1) two physicians who are licensed to practice in Texas and whose medical specialty is ophthalmology;

(2) two optometrists who are licensed to practice in Texas, one of whom must be a member of the Texas Optometric Association and one of whom must be a member of the Texas Association of Optometrists; and

(3) two persons to represent the public who have experience in and an interest in children's visual problems.

(b) Except for those first appointed, members are appointed for terms of six years expiring on August 31 of the odd-numbered years. If a vacancy occurs on the committee, the board shall appoint a member to serve the unexpired portion of the term.

(c) The advisory committee shall serve without compensation; however, the committee members may be reimbursed for their actual and necessary expenses incurred while fulfilling their duties as committee members.

(d) The advisory committee, after approval from the department, may from time to time invite the participation of representatives of professional and volunteer organizations in their activities.

§9. Interagency Committee on Children's Vision

(a) The functioning of the vision screening program shall be assisted by an interagency committee on children's vision. The commissioner of education, the commissioner of human resources, the executive director of the State Commission for the Blind, and the commissioner of health shall appoint one member from their agency to the committee. The committee members shall coordinate preschool and school vision screening programs and the vision health programs in their respective agencies in the State of Texas. The committee may invite the advisory committee on children's vision, authorized under this Act, to meet with it and to offer professional consultation when requested.

(b) The interagency committee shall select one of its members as chairman and may elect other officers that it considers necessary. The committee may meet as often and at any place that it may decide, but shall meet at least once in each calendar year.

§10. Limitation on Authority

Nothing in this Act shall be construed as giving anyone authority to require the maintenance of any forms or filing of reports that were not required prior to the passage of this Act.

§11. Initial Appointments

In making the initial appointments to the advisory committee, the board shall appoint one ophthalmologist and one optometrist for terms expiring on August 31, 1981; one optometrist and a person representing the public for terms expiring August 31, 1983; and one ophthalmologist and a person representing the public for terms expiring August 31, 1985.

Education for the Visually Handicapped

Section BB-33.0

Tex. Educ. Code Ann. §11.052 (Vernon Supp. 1982). See Texas School Law Bulletin 1982, TEA Pub. AD1 013 01.

§11.052.

(a) The Central Education Agency shall develop and administer a comprehensive statewide plan for the education of visually handicapped children under 21 years of age which will ensure that the children have an opportunity for achievement equal to the opportunities afforded their peers with normal vision.

(b) The Central Education Agency shall be responsible for:

(1) the development of standards and guidelines for all special education services for the visually handicapped which it is authorized to provide or support pursuant to the provisions of this code, including matters related to standards and accreditation;

(2) the supervision of such field offices as might from time to time be established to assist local school districts in serving visually handicapped children more effectively;

(3) the development and administration of special programs for children handicapped by both serious visual loss and serious hearing loss;

(4) the evaluation of special education services provided for visually handicapped children by local school districts and the approval or disapproval of state funding of such services; and

(5) the maintenance of effective liaison between special education programs provided for the visually handicapped by local school districts and related initiatives exerted by the State Commission for the Blind, the Department of Mental Health and Mental Retardation, the School for the Blind, and other related programs, agencies, or facilities as appropriate.

Vocational Nurse Act

Section BB-34.0

Tex. Rev. Civ. Stat. Ann., Art. 4528c, §6(a) (Vernon Supp. 1982)

§ 6. Examination and Licenses

(a) Except as provided in Section 7 of this Act, every person desiring to be licensed as a Licensed Vocational Nurse or use the abbreviation L.V.N. in the State of Texas, shall be required to pass the examination given by the Board of Vocational Nurse Examiners or its delegate. The applicant shall make application by presenting to the secretary of the Board, on forms furnished by the Board,

satisfactory sworn evidence that the applicant has had at least two (2) years of high school education or its equivalent and has completed an approved course of not less than twelve (12) months in an approved school for educating vocational nurses. An approved school as used herein shall mean one approved by the Board. Application for examination by the Board or its delegate shall be made at least thirty (30) days prior to the date set for the examination.

Medical Practice Act of Texas

Section BB-35.0

Tex. Rev. Civ. Stat. Ann., Art. 4495b, §3.06(d) (1), (2), (3), (4), (Vernon Supp. 1982).

§3.06. Definitions

(d) This Act shall be so construed that:

(1) a person licensed to practice medicine shall have the authority to delegate to any qualified and properly trained person or persons acting under the physician's supervision any medical act which a reasonable and prudent physician would find is within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician, the act can be properly and safely performed by the person to whom the medical act is delegated and the act is performed in its customary manner, not in violation of any other statute, and the person does not hold himself out to the public as being authorized to practice medicine. The delegating physician shall remain responsible for the medical acts of the person performing the delegated medical acts. The board may determine whether or not an act constitutes the practice of medicine, not inconsistent with this Act, and may determine whether any medical act may or may not be properly or safely delegated by physicians;

(2) a person licensed to practice medicine is authorized and shall have the authority to delegate to any

qualified and properly trained person or persons, acting under the physician's supervision, the act or acts of administering or providing, in the physician's office, dangerous drugs, as ordered by the physician which are used or required to meet the immediate needs of the physician's patients. The administration or provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders, where applicable, as the orders are defined by the board. The administration or provision of dangerous drugs shall be in compliance with laws relating to the practice of medicine and Texas and federal laws relating to the dangerous drugs. This subdivision does not permit the physician or person or persons acting under the supervision of the physician to keep a pharmacy, advertised or otherwise, for the retailing of the dangerous drugs without complying with the applicable laws relating to the dangerous drugs;

(3) a person licensed to practice medicine shall be authorized and shall have the authority to delegate to any qualified and properly trained person or persons, acting under the physician's supervision, the act or acts of ad-

ministering or providing dangerous drugs, if the provision is provided through a facility licensed by the State Board of Pharmacy pursuant to applicable law, as ordered by the physician, which are used or required, to meet the immediate needs of the physician's patients. The administration or provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders, where applicable, as the orders are defined by the board. The provision of dangerous drugs shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, Texas or federal drug laws, and rules that may be properly issued by the State Board of Pharmacy. The administration shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, and Texas or federal drug laws. This subdivision does not permit the physician or person or persons acting under the supervision of the physician to keep a pharmacy, advertised or otherwise, for the retailing of the dangerous drugs without complying with the applicable laws relating to the retailing of dangerous drugs. In this subdivision and in Subdivision (2) of this subsection, 'administering' means the direct application of a drug by injection, inhalation, ingestion, or any other means to the body of the physician's patient; 'provision' means to supply one or more unit doses of a drug, medicine, or dangerous drug. The drug or medicine shall be supplied in a suitable container that has been labeled in compliance with the applicable drug laws. However, a qualified and trained person or persons, acting under the supervision of a physician, may be permitted to specify at the time of the provision the inclusion of the date of provision and the patient's name and address;

(4) in the provision of services and the administration of therapy by public health departments, as officially prescribed by the Texas Department of Health for the prevention or treatment of specific communicable diseases or health conditions for which the Texas Department of Health is responsible for control under state law, a person licensed to practice medicine shall be authorized and shall have the authority to delegate to any qualified and properly trained person or persons, acting under the physician's supervision, the act or acts of administering or providing dangerous drugs, as ordered by the physician that are used or required to meet the needs of the patients. The administration of provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders where applicable, as the orders are defined by the board. The provision of dangerous drugs shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of pharmacy, and laws relating to the practice of professional nursing. The orders may not be inconsistent with this Act and may not be used for the performance of acts and duties that require the exercise of independent medical judgment. In this subdivision, 'administering' means the direct application of a drug by injection, inhalation, ingestion, or any other means to the body of the patient; 'provision' means to supply one or more unit doses of a drug, medicine, or dangerous drug. The drug or medicine shall be supplied in a suitable container that has been labeled in compliance with the applicable drug laws. However, a qualified and trained person or persons, acting under the supervision of a physician, may be permitted to specify at the time of the provision the inclusion of the date of provision and the patient's name and address.

Texas Pharmacy Act

Section BB-36.0

Vernon Ann. Civil Stat., Art. 4542A-1 §§5(2)(a)(b), (8), (12)(a)(b), (34), 29(a), (b), (c)(4), (g) and 33(b).

§5. Definitions

In this Act, unless the context of its use clearly indicates otherwise:

(2) "Administer" means the direct application of a prescription drug by injection, inhalation, ingestion, or any other means to the body of a patient by:

(A) a practitioner or an authorized agent under his supervision; or

(B) the patient at the direction of a practitioner.

(8) "Class D pharmacy license" or "clinic pharmacy license" means a license issued to a pharmacy dispensing a limited type of drugs or devices pursuant to a prescription drug order.

(12) "Dangerous drug" means any drug or device that is not included in Penalty Groups 1-4 of the Controlled Substances Act and that is unsafe for self-medication or any drug or device that bears or is required to bear the legend:

(A) "Caution: federal law prohibits dispensing without prescription"; or

(B) "Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian."

(34) "Provide" means to supply one or more unit doses of a nonprescription drug or dangerous drug to a patient.

§29. Registration of Pharmacies

- (a) A pharmacy shall annually register with the board.
- (b) Each pharmacy shall apply for a license in one or more of the following classifications:
 - (1) Class A;
 - (2) Class B;
 - (3) Class C; or
 - (4) Class D.
- (c) Each pharmacy shall be under the supervision of a pharmacist as follows:
 - (4) a Class D pharmacy shall be under the continuous supervision of a pharmacist whose services shall be required according to the needs of the pharmacy.
- (g) A pharmacy operated by the state or a local government that qualified for a Class D license may not be required to pay a fee to obtain a license.

§33. Administration and Provision of Dangerous Drugs

A person licensed to practice medicine shall have the authority to delegate to any qualified and properly trained person or persons, acting under such physician's supervision, the act or acts of administering or providing dangerous drugs, if such provision is provided through a facility licensed by the board pursuant to Section 29(b)(4) of this Act, as ordered by such physician, that are used or required to meet the needs of such physician's patients.

Such administration or provision, as ordered by a physician, may be delegated through physician's orders, standing medical orders, standing delegation orders, or other orders, where applicable, as such orders are defined by the Texas State Board of Medical Examiners. Such provision of dangerous drugs shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, Texas or federal drug laws, and rules that may be properly issued by the board. Such administration shall be in compliance with any laws relating to the practice of medicine, laws relating to the practice of professional nursing, laws relating to the practice of pharmacy, and Texas or federal drug laws. Nothing in this section shall permit the physician or person or persons acting under the supervision of such physician to keep a pharmacy, advertised or otherwise, for the retailing of such dangerous drugs without complying with applicable laws relating to same. Such dangerous drug shall be supplied in a suitable container that has been labeled in compliance with applicable drug laws; provided, however, a qualified and trained person or persons acting under the supervision of a physician may be permitted to specify at the time of such provision the inclusion of the date of provision and the patient's name and address.

Section CC Sample Forms

Section CC	Sample Forms
	1.0 Daily Report Form
	2.0 School Nursing Summary Sheet
	3.0 Permanent Cumulative Health Record
	4.0 Student Emergency Card
	5.0 Accident Report
	6.0 Head Injury Sheet
	7.0 Animal Bite Record
	8.0 Letter to Parent
	9.0 Daily Log for Medication
	10.0 Physician's Authorization for Special Health Care
	11.0 Specialized Physical Health Care Service: Daily Log
	12.0 Certificate of Examination, Tuberculosis
	13.0 Student Transfer Record

School Health Program Reports

A statistical report is a means of assuring accountability in the school health program. Reporting with statistical data is helpful in revealing work loads, accomplishments, and perhaps deficits.

Many principals, superintendents, and school boards will appreciate a periodic report on the school health program activities. Nurse administrators may wish to include a narrative report along with the statistical data. Narratives in which a particular school nurse has made a special effort to assist an individual student or group are beneficial. A narrative report may also project goals and objectives for future health service programs.

Daily Report Form

Section CC-1.0



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DAILY REPORT FORM

NAME OF SCHOOL: _____

DAILY REPORT FORM					NAME OF SCHOOL: _____		
DATE	IN TIME	STUDENT NAME	GRADE	TEACHER	REASON	DISPOSITION	SCREENING
						Back to Class	Vision
						Parent Contact	Hearing
						Home	Weight & Height
						Physician	Scalp/Skin
						Hospital	Blood Pressure
						Home Visit	Dental
						Other	Scoliosis
							Reportable Disease
							T.B. Skin
							Other
							SIGNATURE & POSITION

School Nursing Summary Sheet



Section CC-2.0

 Dates Covered: _____
 (6 Week Reporting Period)

No. Nurse Extenders: _____

School: _____

Total Visits to School: _____

Enrollment: _____

Average Hours per Visit: _____

I. Health Supervision	No. Pupils	No. Ref.	Referrals Completed		
			Valid Ref.	Rec'd. Tx.	Over Ref.
Physical Assessment					
Health Counseling					
Major Illness					
Minor Illness					
Emergency					
First Aid					
Emotional					
Meds. Supervision					
Special Procedure					
Child Abuse					
Comm. Disease					
Other					
II. Screening					
Vision					
Hearing					
Weight & Height					
Scalp & Skin					
Blood Pressure					
Dental					
Scoliosis					
Reportable Disease					
TB Skin Test					
Other					
III. Health Activities	Students	Classes	Parents	Staff	Community
Health Teaching					
Health Conference					
IV. Staff Development	No.	Hrs. Req.	Other Activities:		
Orientation, self/others					
Supervision					
Class Prep. Time					
Staff Meetings					
Professional Mtgs.					
Professional Growth					
Inservice					
V. Others					
Home Visits					
Community Mtgs.					
School-Sponsored Mtgs.					
Field Trips-Sponsored			Signature and Title		

**Instruction for School Nursing Summary Sheet**

Section CC-2.0

DATES COVERED: One six week report should be completed for each school a nurse covers.

SCHOOL: Name of school, including whether it is elementary, intermediate, or high school.

ENROLLMENT: Total enrollment of school.

NUMBER OF NURSE EXTENDERS: Number of LVN, Aides, or volunteers.

TOTAL VISITS TO SCHOOL: Total number of visits made to the school by the nurse.

AVERAGE HOURS/VISIT: Average number of hours per visit to the school.

I. Health Supervision for Students

These figures will be a cumulative number taken from the daily reporting form and extended to examine those referrals made.

Physical Assessment: Under this category, physical assessment is an assessment of an entire system, i.e., neurological, cardiopulmonary, musculo-skeletal, or an entire physical examination.

Health Counseling: Health counseling may include such subjects as nutrition, cleanliness, crutch-walking, need to wear glasses, or referrals from staff of student problems.

Major Illness/Minor Illness: Whether or not to term an illness "major" or "minor" is subjective and will of necessity be a judgment decision by the nurse. Some examples may be of benefit: a stomachache versus a possible appendicitis; a headache versus a migraine headache; a 99° temperature versus a 102° temperature.

Emergency/First Aid: These categories will also have to be determined subjectively by the school nurse.

Emotional: Children, during stress or having emotional problems, will often seek out a neutral area such as a school clinic. Frequent "headache" or "stomachache" complaints or repeated absences of the same class should provide clues to the nurse that a child may be having other problems.

Medication: A notation in this area will provide inclusion of the child who comes into the clinic to take regular medication. A form showing the child's name, medication, and time should also be kept (sample provided).

Special Procedure: Procedures such as catheter care, catheterization, feeding, suctioning, ostomy care or stoma care should be noted in this category.

Child Abuse: Procedures for reporting and filing a report will be carried out as designated by law. Notation must be careful and complete. Aside from other reports, notation should be made here for cumulative reportings.

Communicable Disease: Communicable disease such as chicken pox, influenza or flu-like illness, or streptococcal sore throats should be noted in this category.

II. Screening

Screening procedures and reporting are self-explanatory. Reporting in a six week period will be of assistance in planning and evaluating of nurse-time.

III. Health Activities

Health Teaching and Health Conference are broken down into the number of contacts on individual and group basis.

IV. Staff Development

School nurses perform many time-consuming activities for which there is no method of reporting.

V. Other Activities

This section, though not staff development, is a job-related activity. It should include time spent during a day for the benefit of the school child.

Accident Report



Section CC-5.0

To be filled in at the time of the accident by the person caring for an injured student who is referred to a doctor:

Student name _____ Phone _____

Address _____ Age _____ Sex _____

Date _____ Time _____ Insurance _____

Grade _____ Teacher _____ School _____

Location of accident _____

Person in attendance _____

Nature of Accident	
Abrasion	Head Injury
Bruise/Bump	Fracture
Burn	Laceration
Cut	Puncture
Convulsion	Shock
Dislocation	Sprain
Other _____	

Part of Body Injured		
Abdomen	Eye*	Head
Ankle*	Face	Knee*
Arm*	Finger*	Leg*
Back	Foot*	Teeth
Chest	Hand	Wrist*
Elbow*		
Other _____		
*Left, right, both		

How did it happen? _____

Were parents notified? Yes _____ No _____

Treatment and disposition: _____

Follow-up: _____

Amount of time lost from school: _____

(Signature) _____

Principal, Teacher, or Nurse

**Head Injury Sheet**

Section CC-6.0

Dear Parent:

Today, _____ (Child's Name) _____ received an injury to the head. Your child was seen in the clinic and had no problems at that time, but you should watch for any of the following symptoms:

1. Severe headache.
2. Excessive drowsiness (awake the child at least twice during the night).
3. Nausea and/or vomiting.
4. Double vision, blurred vision, or pupils of different sizes.
5. Loss of muscle coordination such as falling down, walking strangely, or staggering.
6. Any unusual behavior such as being confused, breathing irregularly, or being dizzy.
7. Convulsion.
8. Bleeding or discharge from an ear.

CONTACT YOUR LOCAL DOCTOR OR EMERGENCY ROOM IF YOU NOTICE ANY OF THE ABOVE SYMPTOMS.

School Nurse

Telephone Number

Animal Bite Record



Section CC-7.0

Date of bite: _____ Time of bite: _____

Name of person involved: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Age: _____ Sex: _____

Breed/Type of animal with general description: _____

Age of animal: _____ Sex of animal: _____

Approximate weight of animal: _____

Date of vaccination: _____ City: _____

Description of incident (on school grounds? to/from school? animal confined, leashed/unleashed? etc.) _____

Area on person bitten: _____

Owner of animal: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Bite reported to: (LOCAL ANIMAL CONTROL AGENCY) _____

Time & Date reported: _____

Signature: _____

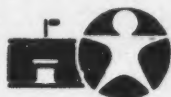
Section CC-3.0

NOTE: All Referrals in Red Ink.

*C-Caries; G-Gingivitis; H-Hygiene; O-Orthodontic; O.K.-No problem

TEACHER OBSERVATION										NAME	D.O.B.	NOTE: All Referrals in Red Ink.													
Use X when defect observed; circle X when corrected H.I.—Record health inventory in first TNC column													Audiometric Screening												
Teacher-Nurse Conference Date										H.I.	Date	Referral and Follow-Up		Nurse	Date	Sweep	Herm	Freq.	250	500	1000	2000	3000	4000	6000
General	Tires easily															R	R	db							
	Under or overweight															L	L	db							
	Posture															R	R	db							
	Muscular coordination															L	L	db							
	Hair, Scalp, Skin															R	R	db							
Eyes	Personal hygiene															L	L	db							
	Eyelids															R	R	db							
	Strabismus															L	L	db							
	Squint															R	R	db							
	Frequent headaches															L	L	db							
Ears	Eyes water															R	R	db							
	Discharge															L	L	db							
	Earaches															R	R	db							
Nose	Does not hear well															L	L	db							
	Freq. colds—nosebleeds															R	R	db							
Mouth	Mouth breathing															L	L	db							
Throat	Freq. sore throat															R	R	db							
Teeth	Oral hygiene															L	L	db							
	Obvious defects															R	R	db							
	Gums															L	L	db							
Behavior Pattern	Disturbs classroom																								
	Nervous/restless																								
	Twitching—fainting																								
	Nail biting																								
	Shy																								
	Over-aggressiveness																								
	Freq. stomachaches																								
	Excessive use of toilet																								
	Peer relations																								
	Doesn't like school																								
Other	Good habits																								
	Speech Problem																								
	General Cleanliness																								
	Excessive Absence																								

P-Passed, Re-Ck, F-Failed, R-Referred



Student Emergency Card

Date _____

School _____

Grade _____

Birth Date _____

Student's Name_____

Last

First

Middle

Address _____

Home Telephone _____

City _____ Zip _____

Zip.

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information for emergency calls:

Name _____

Business Address

Business Telephone

Mother _____

Father _____

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED:

Name _____

Name _____

Address _____ Tel _____

Tel

Address	Tel
---------	-----

Te

HEALTH INFORMATION: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic condition, etc.

Explanation: _____

DOCTOR: 1st choice _____

2nd choice _____

Telephone Number _____

Telephone Number _____

HOSPITAL CHOICE: Address _____ Telephone Number _____

Telephone Number _____

****IMPORTANT—PLEASE COMPLETE REVERSE SIDE OF CARD****



Student Emergency Card

Section CC-4.0

(Back of Emergency Card)

I, the undersigned, do hereby authorize officials of _____
School District to contact directly the persons named on this card, and do authorize the named physicians to render such treatment
as may be deemed necessary in an emergency, for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized
to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent or Guardian

Student's Last Name

First

Initial

**School Health Program
Letter to Parent**

Section CC-8.0

School _____ Date _____

Name of Child _____ Grade _____

Name of Teacher _____

Dear Parent:

In watching the health of your child, the teacher and I have noted the following observations which we feel should be brought to your attention:

Principal _____

Nurse _____

Phone _____

The school would appreciate comments from you or your doctor regarding these signs if you feel the information would be helpful for the nurse or teacher.

Date: _____

Parent's comments OR Doctor's diagnosis, treatment, and recommendations:

Parent's Signature _____

OR _____

Doctor's Signature _____

Daily Log for Medication

Section CC-9.0



Daily Log for Medication

School	Week of					Week of					Week of					Week of				
	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				
Student _____																				
Med. _____ Dosage _____																				
Times _____																				

The person dispensing the medication signs his or her name in the block under the corresponding day of the week.



**Physician's Authorization
For Having Specialized Physical Health Care
Service Procedures Administered**

Section CC-10.0

Name of Student: _____ Birth Date: _____

Address: _____

1. Physical condition for which the standardized procedure is to be performed: _____

2. Name of standardized procedure: _____

3. Precautions, possible untoward reactions, and interventions: _____

4. Time schedule and/or indication for the procedure: _____

5. The procedure is to be continued as above until: _____

(Date)

Physician's Signature_____
Date_____
Address_____
Telephone

I hereby request that the treatment specified above be performed to the above-named child.

Signature of Parent/Guardian_____
Date

Specialized Physical Health Care Service Daily Log of Treatment Administered

Section CC-11.0



Name: _____ Birth Date: _____

School: _____

Procedure: _____

From: _____, 19 _____ To: _____, 19 _____

Physician: _____ Phone: _____

Date Time	Comment	Init.	Date Time	Comment	Init.	Date Time	Comment	Init.

Date Time	Comment	Init.	Date Time	Comment	Init.	Date Time	Comment	Init.

Date Time	Comment	Init.	Date Time	Comment	Init.	Date Time	Comment	Init.

Date Time	Comment	Init.	Date Time	Comment	Init.	Date Time	Comment	Init.

Date Time	Comment	Init.	Date Time	Comment	Init.	Date Time	Comment	Init.

Signatures	Title	Date



Certificate of Examination Of School Personnel for Tuberculosis

Section CC-12.0

This is to certify that _____, No. _____,
NAME first, m.i., last Employee Number
was examined on _____ for the disease of tuberculosis and was found to (be free of) active
(have) tuberculosis. The following were performed in connection with the examination:

Tuberculin test:	DATE: _____	RESULT: _____	Negative reaction
_____ Not done		_____	Positive reaction
Chest X-ray:	DATE: _____	REPORT: _____	Normal chest findings
_____ Not done		_____	Abnormal chest findings

PHYSICIAN'S SIGNATURE

TEXAS MD/DO LICENSE NUMBER: _____

In order to comply with Texas law (VTCS 4477-12, sec. 5), the examination must be completed and the certificate with results must be furnished to the governing board of the public school prior to the commencement of the individual's duties. TB-4, Rev. 8/1/79 (Texas Department of Health).

Student Transfer Record
Healthy Independent School District
Health Services Department
Immunization and Screening Data



Section CC-13.0

**Record ALL
Immunizations!**

NAME (full) _____ Birth Date _____ Grade _____

Address _____ Telephone _____

Parent or Guardian _____

DPT or Td

Date #1

Date #2

Date #3

Date #4

Date #5

Date #6

Physician

Oral Polio

Date #1

Date #2

Date #3

Date #4

Date #5

Date #6

Physician

Rubeola

Date of Vaccine

Date of Disease

Physician

Rubella

Date of Vaccine

Physician

Mumps

Date of Vaccine

Date of Disease

Physician

Vision

R _____ L _____ Date of Test _____

Hearing

R _____ L _____ Date of Test _____

*Schools are reminded that transfer of immunization records (see Section BB-16.0) and screening results (see Section BB-32.0) ARE
REQUIRED BY LAW.

COMPLIANCE STATEMENT

TITLE VI, CIVIL RIGHTS ACT OF 1964; THE MODIFIED COURT ORDER, CIVIL ACTION 5281, FEDERAL DISTRICT COURT, EASTERN DISTRICT OF TEXAS, TYLER DIVISION

Reviews of local education agencies pertaining to compliance with Title VI Civil Rights Act of 1964 and with specific requirements of the Modified Court Order, Civil Action No. 5281, Federal District Court, Eastern District of Texas, Tyler Division are conducted periodically by staff representatives of the Texas Education Agency. These reviews cover at least the following policies and practices:

- (1) acceptance policies on student transfers from other school districts;
- (2) operation of school bus routes or runs on a non-segregated basis;
- (3) nondiscrimination in extracurricular activities and the use of school facilities;
- (4) nondiscriminatory practices in the hiring, assigning, promoting, paying, demoting, reassigning, or dismissing of faculty and staff members who work with children;
- (5) enrollment and assignment of students without discrimination on the basis of race, color, or national origin;
- (6) nondiscriminatory practices relating to the use of a student's first language; and
- (7) evidence of published procedures for hearing complaints and grievances.

In addition to conducting reviews, the Texas Education Agency staff representatives check complaints of discrimination made by a citizen or citizens residing in a school district where it is alleged discriminatory practices have occurred or are occurring.

Where a violation of Title VI of the Civil Rights Act is found, the findings are reported to the Office for Civil Rights, Department of Health, Education and Welfare.

If there is a direct violation of the Court Order in Civil Action No. 5281 that cannot be cleared through negotiation, the sanctions required by the Court Order are applied.

TITLE VII, CIVIL RIGHTS ACT OF 1964; EXECUTIVE ORDERS 11246 AND 11375; TITLE IX, 1973 EDUCATION AMENDMENTS; REHABILITATION ACT OF 1973 AS AMENDED; 1974 AMENDMENTS TO THE WAGE-HOUR LAW EXPANDING THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967; AND VIETNAM ERA VETERANS READJUSTMENT ASSISTANCE ACT OF 1972 AS AMENDED IN 1974.

It is the policy of the Texas Education Agency to comply fully with the nondiscrimination provisions of all federal and state laws and regulations by assuring that no person shall be excluded from consideration for recruitment, selection, appointment, training, promotion, retention, or any other personnel action, or be denied any benefits or participation in any programs or activities which it operates on the grounds of race, religion, color, national origin, sex, handicap, age, or veteran status (except where age, sex, or handicap constitute a bona fide occupational qualification necessary to proper and efficient administration). The Texas Education Agency makes positive efforts to employ and advance in employment all protected groups.